

# The Church and the HIV/AIDS Crisis

## Course Description

This course will provide in—depth and accurate information about the greatest human tragedy of the world’s history — the HIV/AIDS epidemic. It is designed with the hope that, as pastors and Bible School students increase their knowledge of the facts about HIV/AIDS and possible interventions, they will take the lead in developing outreach ministries that will radically change the course of the disease and compassionately touch those who are infected or affected by AIDS.

## Course Objectives

**At the completion of this course students will be able to:**

1. Interpret and apply to their local context the statistical implications of the epidemic worldwide
2. Analyze present cultural, societal and economic implications of HIV/AIDS on a transnational and local level.
3. Accurately describe key characteristics of HIV/AIDS (modes of transmission, myths, signs and symptoms, prevention and treatment).
4. Identify an appropriate biblical response to those affected by the HIV/AIDS epidemic.
5. Construct an appropriate framework for a response by a local church in keeping with Biblical principles.
6. Evaluate the usefulness of transformational development as it applies to the HIV/AIDS crisis.
7. Outline the basic components of Community Health Evangelism and evaluate their usefulness as a framework for an HIV/AIDS response.
8. Critically assess various HIV/AIDS awareness and intervention strategies for church—based response in the student’s cultural context.
9. Develop a response strategy for outreach to groups at high risk for HIV/AIDS for a local church.
10. Determine individualized counseling approaches as they relate specifically to HIV/AIDS and the local circumstances encountered.

## Methodology

The course will be taught by lecture, role play, group discussion and powerpoint. It will begin with a pre—test to determine the level of understanding of the majority of the group concerning the facts about HIV/AIDS. A post—test will be given at the end of the course which incorporates a re—test of the same or similar materials to determine if a change in the knowledge of HIV/AIDS has taken place. Students will be graded on their participation as well as test scores.

## **Accompanying Texts:**

Butrin, J. (1996). *Who will cry for me?* Springfield, MO: HealthCare Ministries.

Butrin, J. (2004). *The HIV/AIDS training manual: What you need to know.* Springfield, MO: A HealthCare Ministries Publication

Butrin, J. (2003). *A guide to train workers in voluntary testing and counseling for HIV/AIDS.* Springfield, MO: A HealthCare Ministries Publication.

Clinton, T. & Ohlschlager, G. (2002). *Competent Christian counseling* (Vol. 1). Colorado Springs, CO:Waterbrook Press.

## Using this Course

**Cultural Relevance** —The course HIV AIDS, is written to try to accommodate various cultural contexts. It attempts to be generic enough to be used worldwide, but may also need to be contextualized to various cultural settings. If there is a desire to rewrite this course to include different cultural components, the rewrite author is asked to collaborate with the primary author in order to protect the integrity and accuracy of the “facts about HIV/AIDS Material”.

**Effective Use of the Course** — The most effective use of the information contained in this manual will be as a classroom course.

The manual is designed to be used in an interactive manner, with student involvement in the teaching and learning process.

Each section begins with a “scenario for discussion” followed by questions about the scenario. Most ideally, students are chosen or volunteer to be ready ahead of the class to present the scenario as a role play. Students are asked to stay as close to the script as possible, though ad lib and emotion may be put into the script to make it more interesting.

The scenarios are important for the following reasons

- To involve students in the teaching and learning process
- To provide a visual and active portrayal of a main point
- To determine the level of knowledge or understanding of key points of the material to be presented
- To allow for the determination of what is relevant in the particular culture or context in which the material is being taught — the question, does this happen in your area provides opportunity for the course facilitator to gain understanding of the cultural context of the particular issue or material under discussion

The scenarios can be changed to make them more culturally relevant but the facilitator should try to instruct the role players to stay with the main point of the scene. If too many different ideas are introduced into the scenarios, the main message does not get across.

**Pre—test — Post—test** — Before beginning the course, the enclosed pre—test should be taken to determine the level of knowledge the students possess about the facts of HIV/AIDS. The Post—test can also be used as a final exam, but covers the main points of the pre—test and can be used as a measure of the effectiveness of the teaching./learning process.

**Questions for Reflections** — Questions for Reflection are designed for the student to use on their own. This may stimulate questions which may be brought back to the classroom for further discussion. For example, each day the facilitator may inquire if there is any discussion based on the questions for reflection. If students will not have a copy of the materials in hand, the facilitator may wish to make copies of the questions for reflection and hand them out at the end of each lesson.

# Table of Contents

## **UNIT 1      The Facts About AIDS**

Lesson One: The Impact of HIV/AIDS on the World.....	5
Lesson Two: Introduction to the Facts of HIV/AIDS .....	15
Lesson Three: Facts About AIDS .....	25

## **UNIT 2      Building a Framework for the Church’s Response**

Lesson Four: What is the Biblical/Christian Response to the AIDS epidemic? .....	37
Lesson Five: Principles of Church/Community Development.....	47

## **UNIT 3      Church—based Interventions for HIV/AIDS as Ministry Outreach**

Lesson Six: The Church and HIV/AIDS Awareness .....	61
Lesson Seven: The Church and HIV/AIDS Intervention Outreaches .....	69
Lesson Eight: The Church Affecting Change in Groups at High Risk for HIV/AIDS.....	79

## **UNIT 4      Counseling and HIV/AIDS**

Lesson Nine: Principles of Counseling .....	87
Lesson Ten: Pre and Post—test Counseling for HIV Testing.....	93

<b>References Cited .....</b>	<b>105</b>
-------------------------------	------------

# Unit 1

## The Facts About AIDS

### Lesson One The Impact of HIV/AIDS on the World

#### Lesson Objectives

At the completion of this lesson students will be able to:

1. Identify the spread of the HIV/AIDS epidemic worldwide
2. Interpret the global statistics in relation to the percentage of infection in the student's local context
3. Critically analyze historical and cultural trends of the student's context which impact the HIV/AIDS epidemic
4. Identify societal behaviors and values which impact the HIV/AIDS crisis
5. Assess the economic status of one's own local environment and analyze the potential or known impact of HIV/AIDS on the economy.

#### Scenario for Discussion/Consideration:

Two men sitting together talking

**John** — Hey, did you see the TV commercial about AIDS? The one where they said there are thousands of people in our country who are HIV positive?

**Richard** — Yeah, I saw that but I don't believe it. Things haven't changed in our town for years. People grow up, they get sick, they die. I think the government is trying to trick us. It's probably a way to stop the prostitution business or something.

**John** — Right, as though that will ever stop. Men will be men!

#### Questions for Discussion/Reflection:

- What is happening in the scene above?
- Why is it happening?
- Might something like this happen where you live? Why?

## Introduction

The HIV/AIDS crisis is creating a scene of human tragedy unlike anything ever seen in the history of the world. Though there have been plagues and epidemics, there has never been a disease that has been so relentless for so long that has claimed the lives of so many.

Usually epidemics are limited to certain parts of the world, but the HIV/AIDS crisis has been found in most all regions of the world. Africa is the hardest hit, with Latin America and the Caribbean being the second highest in prevalence (number of cases per capita).

The HIV/AIDS epidemic, unlike other types of ravishing disease, brings untold human tragedy as it shows no respect for age, race or gender. Also unlike many other epidemics, HIV/AIDS strikes more often at the young than the old.

The epidemic runs rampant across entire nations, leaving in its trail death, destruction, untold sorrow, a weakened or non—existent family and millions of children with no parents and no place to call home.

In many parts of the world where HIV/AIDS is in epidemic proportions, entire nations are said to be either infected or affected by AIDS. It leaves very few untouched in one way or another.

In human terms, there seems to be little hope that the epidemic will be halted in the near future. Though work is being done on vaccines and drugs that will prevent or cure HIV/AIDS, science is not yet close to a cure.

The purpose of this course is not only to increase awareness of the facts about HIV/AIDS, but to understand the epidemic in its sweeping impact on the entire world and especially on areas where it is in epidemic proportion. HIV/AIDS is so much more than just a transmittable disease, but rather it is a phenomenon which affects culture, societies, economies, families and individuals. It needs also to be examined in light of the spiritual impact of the crisis and its affect on the church.

## Worldwide Statistics

It is difficult to list statistics in texts because the numbers are constantly changing. Suffice it to say that millions have died, over 40 million are living with the infection at the time of this document going to press, millions of children are orphaned due to HIV/AIDS and many others have been rendered vulnerable because of AIDS. The following are statistics as of December 2004 taken from the United Nations AIDS bureau and the World Health Organization. These organizations have surveillance teams around the world and usually update their statistics at the end of every year. Please go to the internet site: [UNAIDS.org](http://UNAIDS.org) for the most up—to—date statistics.

<b>Number of people living with HIV/AIDS</b>	<b>Total 42 million</b>
<b>People newly infected with HIV in 2004</b>	<b>5 million</b>
<b>AIDS deaths in 2004</b>	<b>3.1 million</b>

Entire nations are reeling as their work force has died, with entire segments of populations being wiped out. Productivity has declined bringing untold poverty and sometimes ruin to entire regions of countries. With the current trends, entire nations are threatened to be destroyed. The following are the estimated statistics of HIV Infections in the world as of December 2004:

<b>Sub—Saharan Africa</b>	<b>28 million</b>
<b>South and South East Asia</b>	<b>6 million</b>
<b>Latin America</b>	<b>1.5 million</b>
<b>East Asia and the Pacific</b>	<b>1.2 million</b>
<b>Eastern Europe and Central Asia</b>	<b>1.2 million</b>
<b>United States</b>	<b>980,000 thousand</b>
<b>Western Europe</b>	<b>570,000 thousand</b>
<b>North Africa and the Middle East</b>	<b>550,000 thousand</b>
<b>The Caribbean</b>	<b>440,000 thousand</b>
<b>Australia and New Zealand</b>	<b>15,000 thousand</b>

**In the World there are about 14—16,000 new infections daily with 95% occurring in the developing world. Two thousand of those new cases are in children under fifteen years of age and about 50% are women.**

In the Western world, where the majority of HIV positive persons have access to expensive anti—AIDS drugs, the number of new cases is declining. However in less developed parts of the world, antiretroviral drugs (anti—AIDS) are only now becoming available and usually only to those who can afford them. Though these drugs do not cure AIDS, as will be discussed in another lesson, they do help to fight infections and do prolong the life of HIV positive individuals.

According to Unicef’s Social Monitor, September, 2002, “HIV/AIDS is spreading at a faster rate in parts of Central and Eastern Europe and the CIS than anywhere else in the world.”

The report warns — “HIV/AIDS is the greatest threat to health as it moves virtually unchecked into the mainstream population in a number of countries.”

## **Orphans**

With so many deaths, more and more children are losing one or both parents. If one or both are ill from AIDS, the child is made increasingly vulnerable even if not yet orphaned. Therefore when referring to children infected or affected by AIDS one tends to use the term orphaned and vulnerable children. The following statistics indicate children who have lost one or both parents to AIDS:

**There are now about 13.4 million AIDS orphans in the world.**

**The figure is expected to rise to 40 million by 2010.**

The systems that would normally embrace orphaned children are fast disintegrating. As more and more family members die, there is often no extended family to which the children can go. Or if family is present, it may be too overtaxed to wish to feed another child. Often, if children are taken in by extended families, they can face discrimination, beatings, sexual abuse and malnutrition. More will be said about orphaned children in later chapters.

## **Africa**

The epicenter of the HIV/AIDS epidemic remains in sub—Saharan Africa. Sub—Saharan excludes the countries of North Africa and the Middle East. Though other continents are rapidly developing focal points of infection, about two—thirds of the HIV positive persons live in sub—Saharan Africa.

A continent already depleted by wars, political instability, economic depression and other life—threatening diseases, the HIV/AIDS epidemic has further weakened a continent already in distress.

Some African countries such as Uganda with intensive promotion of the *Abstinence, Be faithful and Condom use* message, has managed to stop the increase in new cases. There are signs that the epidemic has leveled off in Zambia where the one in five prevalence has remained stable since the mid 1990's. However other countries such as Botswana, Lesotho, Namibia and Swaziland, according to UNAIDS, 2003, are seeing a devastating rise in the number of cases with no signs of leveling off. The national prevalence of HIV in Swaziland and Botswana at the end of 2004 was 39%.

Eighty percent of the world's children orphaned by AIDS reside on the African continent and this number is projected to rise dramatically over the next eight to ten years. More than 11 million children under the age of 15 have lost one or both parents to HIV/AIDS in sub—Saharan Africa.

## **Latin America and The Caribbean**

Latin America and the Caribbean are in the news as the epidemic rapidly spreads. The Caribbean has the highest prevalence of HIV in the world, outside of sub—Saharan Africa. Guyana has the second highest number of reported cases in the Caribbean Region next to Haiti with the Dominican Republic following close with rising numbers. It is also one of the five countries in the Latin American and Caribbean region in which HIV has spread beyond at—risk populations into the general population (UNAIDS, 2002).

## **Asia**

Asia has had a dramatic increase in the number of HIV infections in the last five years. The UNAIDS (2003) reports that the main modes of transmission of HIV in Asia are IV drug use and commercial sex trade.

India with over 4 million persons who are HIV positive has the largest number of cases of any single country in the world. China as it begins to undertake stronger surveillance is on the verge of becoming an epicenter for HIV in Asia.

## **North America**

Although the numbers of new cases is declining in the United States and Canada, AIDS related death was the second highest cause of death for a number of peak years.

With drugs keeping HIV positive persons alive longer in the US, the number of AIDS—related deaths is declining, but the number of new infections is not.

## Main Modes of Transmission

Though the issue of transmission will be discussed in more detail in later lessons, it is of interest to note the geographical differences in the ways in which HIV is transmitted the majority of the time (All areas that are mentioned also have other modes of transmission — this list is the primary mode):

- Heterosexual — Africa, primarily, shifting in North America to be the primary mode
- IV drug use — Primary mode for most of the Baltic nations, Russia and Central Asia.
- Homosexual — Primarily in the more developed world
- Mother—to—child — In most of the developing world

## Statistics and the Human Tragedy

Statistics are important to the world and to individuals in an attempt to understand the global scope of the crisis. However, when one hears a figure of 42 million it is difficult for the human mind to comprehend exactly what that kind of number means to the individual or family who is part of that statistic. As a practitioner, a pastor or a Christian, it is helpful to be able to translate the statistics into a person facing a life—threatening illness and a family reeling with loss and grief. Often the crisis of AIDS becomes most real when a loved one, a friend or a church member is known to be HIV positive. However even when the crisis has not yet had personal affect, it is possible to pray and ask the Holy Spirit for illumination of the crisis on a personal level. One cannot wait until the crisis comes to one’s back door, but compassion and action are urgently needed now.

### Scenario for Discussion/Consideration:

Jean stood by in humiliation as her husband brought a mistress right into their home and took her in the bedroom. It wasn’t the first time. When she had complained and threatened to leave, she was badly beaten by her husband. She wanted to leave but feared that she had no ability to support her three children. She was pregnant when her husband became very sick and subsequently died. She didn’t know what had killed him.

### Questions for Discussion/Reflection:

- What is happening in the scene above?
- Have you known this type of thing to happen in your area?
- If you were in Jean’s shoes, what would you do?
- How might this scene end?

## Culture, Society and Economics

Understanding the facts about the disease of HIV/AIDS is important for everyone, since it is a global challenge. However, it is necessary and important to understand the broader implications of the epidemic and the factors which also impact the disease. This lesson will challenge students to position the epidemic in the framework of individual cultures, societies and national economies. Obviously these factors will differ from country to country and possibly even within countries from

region to region. The student is asked to look at how these indicators might be translated into his or her individual setting and belief system.

## **Culture and HIV/AIDS**

**Definition of Culture** — Culture can be defined in many ways, but a simple way of looking at it is as “a way of life of a group of people—the behaviors, beliefs, values, and symbols that they accept, generally without thinking about them, and that are passed along by communication and imitation from one generation to the next (SPCM 301).”

The above definition when applied to the AIDS crisis can open a window of understanding as to why the HIV/AIDS crisis is viewed differently from culture to culture. Below are a few of the many ways in which culture impacts HIV/AIDS. This is not a complete list and the student is challenged to look at his or her own culture and identify specific cultural indicators which could potentially impact the HIV/AIDS crisis.

**Gender Inequalities** — Gender inequality can and is having an impact on the HIV/AIDS crisis. The way in which men and women are viewed is usually culturally determined. In some cultures women are viewed in a lesser role or as having less value than men. This can consequently put women at higher risk for contracting HIV/AIDS. HIV is more easily transmitted from men to women. Often women are taught to defer to the male and therefore cannot say no to sexual advances. At times women cannot accuse their husbands of unfaithfulness, nor refuse to participate sexually for fear of abuse or desertion. Women often have less educational opportunity, are illiterate and not in a position to hear or read teaching about AIDS. These all contribute to their vulnerability to contract HIV/AIDS and transmit it to their unborn children.

**Sexuality and Sexual Practice** — Culture defines what is meant by sexuality and what is acceptable behavior for sexual practice. If promiscuity and unfaithfulness are acceptable or permissible norms of a culture, this greatly impacts the spread of HIV/AIDS. If younger women tend to have sex with older men, this will also increase the vulnerability of women to HIV/AIDS.

**Beliefs and Superstitions** — Depending on belief systems, the HIV/AIDS crisis can be attributed to curses, gods, or other superstitions. This can bring denial to the ways in which HIV is transmitted and can cause the seeking of “cures” that correspond with the belief.

**Children and Adolescents** — The way in which children and young people are viewed in a society can impact the way they are taught about sexuality HIV/AIDS, and the ways in which they are cared for when orphaned or rendered vulnerable by the AIDS crisis. Culture defines whether children are raised to be independent in their thinking and behavior or whether they are part of a larger community on which they depend for behavioral guidance. This can have impact on the way in which children cope if abandoned, orphaned or made vulnerable by the HIV/AIDS crisis.

**Learning Styles** — Culture often defines the mode in which information is transmitted from one person to another and from one generation to another. This may be by storytelling and more of a hearing mode of information transmission. Whereas in other cultures, learning is much more visual. The way in which people learn, i.e. by visual as opposed to auditory, or “doing” styles can affect the way in which AIDS awareness programs are developed. Many cultures of the world

are more visual than auditory and will respond more to messages that involve visual and doing modes. More will be said about adult learning styles in a later section of the course.

**Optional Exercise — Demonstration of Preferred Learning styles** (taken from,

Make up signs with 3 large letters on each: AVK, AKV, VAK, VKA, KAV, and KVA and post them on the walls around the classroom. These stand for Auditory, Visual and Kinesthetic.

Ask the class to think about their preferred learning style and give them the following information about each style:

**Auditory** — Learning through hearing — likes to listen to debates, audio tapes, lectures, etc

**Visual** — Learns through seeing; likes to see pictures, diagrams — likes to watch videos

**Kinesthetic**—learns through physical activity and through hands—on moving, touching and experiencing

After reading the descriptions, ask the students to go to the sign that best represents their preferred style of learning. It is of interest to note where the majority are and then discuss ways in which knowledge is generally transmitted in that particular culture.

**Rites of Passage** — “Cultural rites of passage from childhood into adulthood, although traditionally serving to unite communities, can increase risks for HIV” (Population reports, 2002). For example male and female circumcision using knives and blades that can contain contaminated blood is a cause of HIV transmission. Some cultures define “manhood” by the first sexual act and condone early sexual activity for young men. Other cultures use cutting and scarification to introduce various life stages, usually passing from childhood into adulthood. These culturally defined practices can put persons at risk for HIV transmission.

## **Social Implications of HIV/AIDS**

Society refers to the way in which a group of people behaves based on their culture and values. Society can be impacted by the HIV/AIDS crisis and society also have impact on the crisis. The implications of HIV/AIDS on society are many and only a few will be listed below. Probably the most striking is the stigma of the disease in most societies and how that affects the way in which people perceive the disease itself and persons with HIV/AIDS.

**Stigma** — A great hindrance to the prevention of AIDS transmission is the stigma attached to it. The group of people which make up a society decide on what is and is not acceptable. Society dictates how persons with HIV/AIDS will be viewed and in many societies because of lack of information and/or fear and superstition, AIDS and a person with AIDS is viewed with fear and therefore stigmatized. The stigma of HIV/AIDS prevents open communication on the subject. It allows for discrimination against those who may have it. It keeps people from being tested for

HIV. It has been instrumental in preventing the church from taking an active role in prevention and intervention in earlier years of the epidemic and even until the present in some areas of the world.

**Depletion of Energy** — Poverty, hardships, disasters and other negative life forces can deplete the motivation and energy of an entire group or society of people, making it difficult to rise to the challenge of fighting an epidemic. It takes an awareness and willingness of large numbers of people to make a difference in a crisis as overwhelming as that of AIDS. Often due to many years of chronic distress, societies find it difficult to come up with the spirit of participation that will truly turn an epidemic around.

**Government and Politics** — HIV/AIDS is a political issue and the way in which the epidemic is viewed and addressed by government leadership can greatly affect the way in which it is viewed by the society over which they govern. An example of the difference that can be made is that of Uganda. Uganda is one of the few countries in Africa that has been able to turn the tide of rising HIV infections and has, over recent years, seen a decline in the numbers of new cases. The initiative to begin a massive campaign that reached into every segment of society came from the very top leadership of the country and filtered through local government leadership. The church and the government worked closely together in this case, along with secular non—government organizations (NGO's) and positive results occurred. Governments can be in a position of control regarding the use and funding for antiretroviral drugs, which can greatly determine the course of the epidemic in any given country.

**The Breakdown of Family Systems and Tradition** — The “family” has been one of the most redeeming qualities of many developing nations. A strong family bond, which usually included a large extended family, has helped to keep poverty from destroying the family. Elders have been cared for by younger family members; children, if orphaned have been subsumed by family members and wealth and resources have been shared. With the AIDS crisis causing the death of so many family members, the entire support structure has broken down and, along with it, the traditions that have been passed on from one generation to another.

The AIDS crisis has turned everything around and now finds grandmothers caring for sick children and then dealing with many grandchildren after the death of their adult children from AIDS. The crisis has caused the loss of the extended family which would normally have taken in the orphaned children thereby causing the children to go to the streets and become susceptible to contracting AIDS themselves.

**Educational Deficits** — With so many teachers dying of HIV/AIDS, family systems breaking down, and children having no support system, educational systems are also breaking down. Many children, even if not orphaned cannot afford school fees. Many schools have lost their teaching force due to AIDS. The implications of educational decline is devastating for nations already struggling to rise out of poverty cycles.

## **Economic Implications of the HIV/AIDS Crisis**

Many of the nations that are being most affected by the AIDS epidemic are those which have already been struggling with economic depletion, overwhelming health issues and/or political and ethnic upheaval. Many of the countries have experienced natural disasters or may have been at war for years. Thus prior to the onset of AIDS, the countries considered to be part of the

developing world were already reeling from devastating issues which caused poverty, poor health and economic collapse.

The onset of HIV/AIDS in these countries has been, for many, a blow from which some say they will never recover. The largest economic impact has been that of the loss of the workforce.

In places where the epidemic has matured, such as in sub-Saharan Africa, households are facing exorbitant health costs, labor shortages, a declining asset base, lack of adequate amounts of food, and a lack of basic product necessities.

Economics and politics also account for the lack of access to antiretroviral drugs (ART), which help to prolong life and avoid the onset of full-blown AIDS. HIV positive pregnant mothers may not have access to ART's which could reduce the risk of transmitting the virus to their babies during birth. Medications to treat secondary infections that accompany AIDS may also not be affordable.

The following is a list of just a few of the issues related to economics and HIV/AIDS:

- Loss of work force
- Trauma and emotional distress
- Decrease in productivity resulting in lack of food and goods
- Increase in malnutrition and illnesses related to malnutrition
- Increased need of health care, but decrease ability to have access
- The elderly deprived of caretakers
- Migration to find improved life, resulting in spread of HIV
- Existent poverty made worse by HIV/AIDS
- Loss of property inheritance for widows and children due to lack of legal advice
- Increase in crime as desperation to meet survival needs increases

### **Questions for Reflection:**

- If you were to get up in front of your church and show slides of AIDS statistics in your country, how would the congregation respond? Why?
- What are the ways in which your own culture might impact the HIV/AIDS crisis?
- Can you list several important factors of your own life that are defined by the culture in which you live?
- How does your society view the AIDS epidemic and persons with AIDS?
- How would you describe the economic situation of the area in which you live?
- How would your economy be affected by HIV/AIDS?
- How does the political situation in your local and national government affect the HIV/AIDS crisis?
- Are people simply products of their culture with no ability to make changes? If so, why or why not?
- Can you as an individual change anything about the society in which you live? Why or Why not?



## Lesson Two

### Introduction to the Facts of HIV/AIDS

#### Lesson Objectives

At the completion of this lesson students will be able to:

1. Explain the working of the human immune system in fighting infection and the way in which HIV destroys its function.
2. Describe the various modes of transmission of HIV and which of the modes is most commonly associated with the student's own geographical context.
3. Identify common myths and misconceptions about HIV transmission and identify those which might be found in the student's own culture.
4. Explain the "condom theory" of protection against HIV and analyze the appropriateness of condom usage for high risk groups in the student's own context.

#### Scenario for Discussion/Consideration:

Bill and Stephen speaking together:

**Bill** — I've sure been hearing a lot about this AIDS disease. They were even talking about it at the youth rally.

**Stephen** — Me too. My father thinks it's a curse. He's heard that from some of the other men. I think they are kind of scared. I'm not scared though. It won't happen to me—I am so healthy.

**Bill** — Yeah, me too. Might as well have a good time while we're young.

#### Questions for Discussion/Reflection:

- What is happening in the above scene?
- Do people believe in superstitions or curses in your area?
- Have these been attributed to AIDS?
- What is the attitude of young people toward this or any illness in your area? Why?

## **Introduction**

The HIV/AIDS crisis is about much more than the disease itself. As shown in the first two lessons, it is important to understand the HIV/AIDS epidemically globally and more importantly to understand its impact on society and the economy. It is also important to look at the impact of culture and the values and beliefs stemming from one's culture that impact the HIV/AIDS epidemic.

It is also important for every person, but especially for persons in leadership positions or positions of influence to have accurate knowledge of the HIV/AIDS disease itself. One cannot address the any aspect of the crisis without adequate knowledge of how the disease is transmitted, how it is prevented, what it does to the body, how it is treated and what can and needs to be done to give assistance to persons with AIDS and their families.

There are many misconceptions about the disease itself and with accurate knowledge these misconceptions can be addressed. If one is going to speak to this crisis in any way, then the speaker needs to know the facts about AIDS. Therefore the next two lessons will give the basic facts about HIV and AIDS. Pastors, spiritual leaders, teachers, and of course health professionals are in positions of transferring this knowledge to others and thus have a responsibility to be well informed.

Usually people will ask questions about HIV/AIDS that may not be in this lesson. It is important for anyone who is going to teach about this subject to read as much as possible about it from credible sources. Please refer to the Bibliography of the course for sources that have been reviewed and are considered to be credible.

Having a health professional teach the more technical sections may be a good idea if they are able to gear the information to the lay level. Some health professionals are good at this but others use too many big words and technical language and do not communicate well. It may be well to have a health professional standing by, however, should questions arise that the teacher may not know the answer to. If a health professional isn't present, it is best to simply defer the question with a "I don't know the answer but will find out" and try to get back to the person or group with the question.

## **The HIV Virus**

The Human Immunodeficiency Virus (HIV) was discovered in about 1983. Symptoms of the disease later called AIDS, were present in the mid to late 1970's. In 1999, a team of researchers felt they had isolated the virus in a chimpanzee which is native to Western Equatorial Guinea. No one is absolutely certain in what part of the world it originated or how it started spreading from one person to another.

## **The Body Defenses Destroyed**

When the virus enters the body, it begins to attack cells of the body which are called T—cells (These are also called CD4 marker cells and T 4 cells which all mean the same thing. These are part of the white blood cells of the body called lymphocytes). These are part of the defense mechanism of the blood which helps people to fight off infections. HIV multiplies inside the T—cells until the cells burst and are destroyed.

When there is no longer a defense system in the body because the T—cells are disabled, bacteria, other viruses, cancers and fungus all begin to take over the body. A person is "defenseless" against all of these invading organisms.

It is at this time that people are said to have **AIDS**. The body can no longer fight off disease because the immune system is weakened. In some countries where counting T—cells is possible, the diagnosis of AIDS is given when the T—cell count drops to a certain point. In other countries, where this type of laboratory test is not possible, AIDS is diagnosed by the symptoms a person has.

Often people have the virus for TB living in their body but the defense system of the body manages to keep it from growing or doing any harm. But when the T—cells are destroyed, the TB bacteria comes alive and begins its destruction of the lungs and other body organs. In many countries, if people have AIDS, they also have TB and often if people are diagnosed with TB, the presence of HIV is also suspected.

Persons with AIDS (PWA's) often die from secondary conditions such as pneumonia, extreme fluid and weight loss due to diarrhea, and cancer.

## **HIV Can Stay Inactive for Years**

HIV can come into the body and “lie dormant,” that is become inactive for a number of years. People have been known to live as long as 15 years with the virus though they are often taking special anti—AIDS (antiretroviral—ARV) drugs to prolong their lives.

People who do not have access to these drugs can still live from 8 to 10 years after infection especially if they are able to maintain good nutrition and are not in areas where there are many other illnesses such as TB and malaria to wear down their bodies.

## **Staying Healthy During HIV Infection**

Living long and well can be contributed to things like good and adequate food, spiritual and emotional strength and early treatment of infections. Unfortunately not everyone has access to all of the above.

Good nutrition has been shown to be helpful in the ability to fight off infections associated with AIDS. Unfortunately due to the decrease in production of foods and/or the inability to afford adequate amounts and appropriate kinds of foods, persons with HIV are often unlikely to be able to eat properly.

For a pregnant woman, a lack of vitamin A has been shown to cause a greater risk of transmitting the HIV virus to the newborn during delivery. More of the virus is shed into the genital secretions when Vitamin A is not sufficient in the body (World Health Organization/UNAIDS, 1999). Vitamin A can also help to fight off infections.

Pregnant women and anyone who is HIV positive should be advised to try to eat foods which contain vitamin A, particularly green leafy vegetables, carrots, other vegetables and some fruits. A vitamin supplement which contains at least 10,000 units of Vitamin A is useful if adequate foods cannot be consumed (International Vitamin A Consultation Group (IVACG, 2001).

Anemia, resulting from a lack of iron in the diet can precipitate early delivery in pregnant women and cause the HIV/AIDS disease process to bring death sooner. Therefore it is very important for anemia to be discovered and treated either by diet, iron tablets or injections.

Foods high in iron are meats, especially organ meats such as liver, beans, eggs (especially the yolk) and dark green leafy vegetables are recommended for anyone who is HIV positive.

## No sign of Infection but Capable of Infecting Others

Even though there are no signs or symptoms that a person has been infected, HIV can be transmitted to others immediately after it enters the body. This is due to its quick multiplication in the blood and sexual secretions.

Often people make the mistake of thinking that because someone doesn't look sick they cannot possibly be HIV positive. Or other people think that because they don't feel sick, they couldn't have the virus. Unknowingly, they may have sex with someone and end up infecting them. Husbands with no symptoms can infect their wives. Women, with no symptoms can infect their husbands. Prostitutes who look healthy can infect many of the men who frequent them. Young men and women participating in premarital sex are infecting each other usually with no knowledge that they one or the other or both are HIV positive.

## Transmission of HIV/AIDS

### Scenario for Discussion:

Two women talking while working:

**Louise** —You seem quiet today, what's wrong?

**Susan** — I am worried about things in my marriage. I think my husband has a mistress or maybe even more than one. But of course he still wants to come to bed with me too.

**Louise** — I've given up thinking it can be any different. Men are just that way.

**Susan**—But what if he gives me some disease? I heard that you can get AIDS if your husband sleeps around. I've tried to speak to him about it but he just laughs or gets mad.

### Questions for Discussion:

- What is happening in the scene above?
- How might this scene be different in your area?
- Do husbands and wives tend to talk about marital problems?
- How common is infidelity in marriage?

## Modes of Transmission of HIV

HIV is transmitted or passed from one person to another by:

- Blood
- Sexual secretions (semen or vaginal secretions)
- Breast milk

## **This can happen by:**

- Sexual intercourse with a person infected with HIV.\*
- Using the same needle or syringe that has been used by or on someone infected with HIV.
- Contaminated dental equipment (or any instrument that cuts the skin) that has been used on someone infected with HIV.
- Receiving blood transfusions or blood products that contain HIV.
- An HIV—infected mother passing HIV to her baby during pregnancy or while the baby is being born.
- A baby drinking breast milk from an HIV—infected mother.

\*Sexual intercourse is the most common way in which HIV is transmitted.

## **Most Common Modes of Transmission Differ by Regions of the World**

Though sexual transmission accounts for most cases of HIV in the world—as of the writing of this text—there are parts of the world where one mode of transmission is most dominant. The following give highly infected areas and how the transmission is most commonly happening:

### **Africa**

In Africa HIV is usually due to sexual intercourse between persons of the opposite sex (heterosexual). Women in Africa are at least 1.2 times as likely to be infected with HIV as men (UNAIDS, 2003). This higher incidence in women is attributed to the fact that HIV is more easily transmitted to women than men, sexual activity tends to start earlier for women and young women tend to have sex with much older partners (UNAIDS, 2003). The highest incidence of mother—to—child transmission is occurring in Africa and there are cases, though a small percentage, that occur through infected blood supplies or contaminated instruments.

### **The United States, Latin America and other parts of the world**

In the United States and many other parts of the world, HIV is transmitted by homosexual activity as well as heterosexual and by IV drug users. Transmission through the heterosexual mode has increased in the Western world in the last 10 years. In Columbia and Peru, HIV spread is most marked among men having sex with men. Eighty percent of the transmission of HIV in Guyana and Haiti is the heterosexual mode.

### **The Former Soviet Union**

In the former Soviet Union, the Baltics and Central Asia intravenous drug use is the main mode of HIV transmission, though there is still minimal transmission by other means.

## Mother—to—Child Transmission

In many parts of the world, especially where antiretroviral drugs are not extensively used, mothers are transmitting the virus to the baby:

- During pregnancy
- During delivery (most common)
- While breast—feeding

Twenty—five to 35% of HIV—positive pregnant women will pass the virus to their babies by one of the three ways mentioned above.

## Contaminated Instruments and Blood Supplies

Dental and medical instruments, needles and blood transfusions account for some transmission but not nearly as much as sexual transmission, IV drug use and mother—to—child transmission.

### Scenario for discussion:

Mother talking to teenage daughter.

**Mother** — Come on Karen. We are going to see your sister. I think she needs help with the kids.

**Karen** — Mom, I don't want to go over there. I have too much homework to do.

**Mother** — Karen, you haven't stopped in to see your sister for weeks. She's so sick and really needs our help. Besides, I think she'd like to see her little sister.

**Karen** — Mom, I really don't want to go. Last time I was there she hugged me and I'm so scared that I got what she has.

### Questions for Discussion:

- What is happening in the scene above?
- What is right about this scene?
- What is wrong? What information is lacking?
- Are these types of misconceptions prevalent in your area?

## Ways in Which HIV is NOT Transmitted

Due to a lack of information or misinformation, many people fear to go near someone who is HIV positive. Education is so important and is a great first step for anyone, including the church, who is preparing to reach out to those in need. The following is a list of ways that HIV is **not** transmitted:

- Shaking hands, touching, or hugging

- Kissing on the cheek or lips
- Using the same eating utensils
- Riding in crowded buses or in cars
- Swimming or bathing together
- Bites from mosquitoes or insects
- Being together in the same room
- Using the same toilet seats

## **Fear of Infection**

Many people are afraid to go near someone if they know that he or she is HIV positive. Usually this is because people are not well informed.

There are many superstitions and misconceptions about the ways in which the virus is passed from one person to another.

It is very important for people who are sick with AIDS to feel that they are not rejected and that people are not afraid of them.

Casual contact is defined by the list above. Though it is not advisable for an HIV positive person to go into a swimming pool or bathing area with others if there are open, draining sores, even this risk is minimal.

Many studies have been done of people who live in the same house or who care for someone with HIV and even with contact every day, no one has been found to have contracted HIV in this way.

## **Beliefs about AIDS that are Not True**

Many superstitions and myths have developed about AIDS since the disease was recognized in the 1980's. Some cultures are more given to superstition than others, but almost all cultures have some superstition or folk beliefs. Often these are applied to the AIDS epidemic as will be seen in the examples that follow:

### **God or Governments**

AIDS has been ascribed to curses, to an angry god or gods. It has been called punishment from God. It has been termed a government conspiracy and some have thought it was chemical warfare. Many Christians feel that the AIDS crisis is a judgment from God.

**Optional Discussion Group Activity** — Divide the class into two groups and ask them to debate the question, “Is the AIDS epidemic a judgment from God?” Ask the group to back up their debate with scripture reference. Have the group choose a reporter to present the conclusions of the group. More will be said on the topic in a later lesson.

## False Claims of Vaccines or Medical Cures

In addition to beliefs about where AIDS comes from are beliefs about how to “cure” it. Unfortunately a cure for AIDS has not yet been found. There are often announcements of “cures” around the world—someone or a group who believes that they have found the cure, but usually those claims prove to be false.

**Folk Cures** — There are also some “folk” cures that have arisen such as the idea that if a man has sex with a virgin, a baby, or a young child, he will be cured. This is a very harmful belief, as the HIV will be spread during the attempt to cure. There are also beliefs that certain herbal preparations can cure AIDS and this too has proven to be untrue. There are herbal preparations and other folk or traditional remedies that may cause a person to feel better or which may alleviate some of the symptoms a person has. However, none of these has been scientifically shown to result in a cure.

### Scenario for Discussion:

Two young men talking together.

**Henry** — What did you think of the program at school today? I couldn’t believe it when they blew up that condom.

**John** — Yeah, that was pretty funny. What were they trying to say anyway? I thought sex with condoms was safe. They gave the idea that it wasn’t true.

**Henry** — I think they were just trying to scare us so we don’t have sex. I think its all a lot of hype. I’ve been having sex without one—I’m just careful and nothing ever happens.

### Questions for Discussion:

- What should the stance of the church be when it comes to condom use?
- Is it appropriate to tell young people that if they are going to have sex they should use a condom?
- What about condom distribution for high—risk groups like prostitutes?

## Condoms

People also believe that if they use a condom during sexual activity they will be safe. Though condoms do provide protection they are not 100% safe. The reasons they are not safe are:

They may be used inconsistently or incorrectly, such as use with an oil—based lubricant instead of a water—based which can weaken the condom

They can tear, but latex condoms manufactured according to regulatory standards rarely tear if used properly (Center for Disease Control, 1993).

If condoms are not manufactured according to regulation or are not latex, they may be of poor enough quality to allow the virus to pass through the condom. This will not happen with a high—quality condom.

Though condoms are a controversial issue especially in the church world, they do provide protection against HIV transmission if the above conditions are met. If in marriage, one partner is HIV positive and the other is not, they should definitely use condoms to protect the other from being infected.

## **Questions for Reflection:**

1. How much of the information in this lesson is new information to you?
2. Did you yourself have any misconceptions that have now been made clear? If yes, what?
3. Do you think that most people in your area are aware of what HIV actually is and what it does to the body? If no, why not?
4. Do you think that people know that they can infect others even if they have no symptoms? Why do you feel this way?
5. Do you think it should be a health professional who teaches this type of information? Why or why not?
6. Do you know how HIV is most frequently transmitted where you live?
7. What, if anything, should the church have to do with imparting information about HIV transmission? Why or why not?
8. Do churches in your area actively address issues about HIV/AIDS? Why or why not?
9. How is the issue of condoms dealt with? What is your personal view?



# Lesson Three

## Facts About AIDS

### Lesson Objectives

At the end of this lesson students will be able to:

1. Accurately describe the most common signs and symptoms of AIDS and distinguish between HIV infection and full—blown AIDS.
2. Critically evaluate ways in which HIV transmission is prevented and how prevention messages may be accepted in the student's own culture and context.
3. Explain the probability of co—infection with HIV/AIDS and Tuberculosis
4. Critically evaluate the ABC prevention model for HIV and analyze its usefulness in the student's own context
5. Identify the ways in which HIV positive pregnant women transmit HIV to their babies
6. Evaluate the ways in which HIV testing can be a prevention strategy and how that might be applied in different cultures
7. Assess the role of stigma as a deterrent to prevention of HIV particularly in the student's context.

### Introduction

It is important for anyone in HIV/AIDS epidemic areas to be well informed about the symptoms of HIV/AIDS, but even more important that ways to prevent transmission be understood. This lesson will look at signs and symptoms, realizing that the disease may manifest itself somewhat differently in different parts of the world. It is not felt that an in—depth knowledge of all the disease processes associated with HIV/AIDS need to be known or understood, but rather the most common symptoms be addressed.

### Signs and Symptoms of AIDS

#### Introductory Story

Anthony made his parents very proud. He finished his accounting degree and went to the city to work. He made good money and planned to marry when he had saved enough to buy a nice house. Meanwhile, he liked to have a good time. He went out dancing and usually brought a girlfriend home at night. He'd get tired of one and find another one easily. He hated condoms and didn't use them.

One day he began to notice some lumps on his neck and under his arms. He'd wake up sweating at night and have fevers. Sometimes he'd notice a skin rash too. He finally went to the doctor to see what was wrong. He was stunned when the doctor said he might have AIDS.

## Early Symptoms

As stated earlier, people can have HIV in their bodies for a number of years and have no symptoms at all. This is what makes it so dangerous. People are spreading it around and don't know that they have it.

Some people do experience slight symptoms right after they are infected with HIV. They may have flu—like symptoms and a mild fever that may last a week or a few weeks and then go away. Few people think this is more than a usual “bug” or virus and don't get checked medically.

There may be no other symptoms for years after the flu—like symptoms. Not everyone experiences even the mild symptoms and are surprised when they find out they have been infected with HIV.

**It is good to emphasize again that from the time a person is infected with HIV, they are able to transmit it to others through their blood or sexual contact to someone else.**

## Most Common Signs and Symptoms of AIDS

The symptoms listed below are the ones most commonly associated with AIDS:

- Gradual weight loss
- Diarrhea for more than one month
- Lack of appetite
- Fungal infections in the mouth that look like white patches
- Skin rashes and infections
- Feeling tired all the time
- Cough and symptoms of tuberculosis

These can be symptoms of other illnesses. The only way to know whether or not it is AIDS is by being tested. If a person has the above symptoms and tests positive for HIV, then that person is said to have AIDS. Prior to the beginning of the above symptoms, a person is said to be HIV positive but being positive does not mean having AIDS.

**Remember that having HIV in the body does not mean a person has AIDS.** But it does mean, without antiretroviral drugs, the HIV will eventually become active and begin to destroy the T—cells allowing for other infections begin to take over the body. When the T—cells become low enough, and/or the above symptoms begin and a positive HIV test occurs, then a person is said to have AIDS.

(Antiretroviral drugs are not a cure for AIDS—but do help to prolong life by keeping the HIV from becoming active or more active.)

## Weight Loss

For some, the first signal that something is wrong is when they begin to lose weight. Persons often lose six to seven kilos (13—15 pounds) of weight when they first begin to notice symptoms.

The weight loss is often unexplained and unrelated to any particular illness going on. The muscles of the body can begin to waste away or lessen in mass at this time. When and if diarrhea occurs, this usually causes more weight loss as more is being lost from the body than being taken in.

## **Diarrhea**

In some countries, Africa in particular, diarrhea is a common first symptom. There are many things that cause diarrhea, such as parasites and bacterial infections, so having diarrhea is not uncommon for many people. However, diarrhea associated with AIDS does not go away with the usual treatments and persists for weeks or months. If diarrhea is present for a month, it is often associated with AIDS. It causes weight loss and lack of appetite. People who were thin, malnourished or sick before the diarrhea started, can go downhill very quickly and die from dehydration and wasting.

However, there are drugs which help to combat diarrhea and medical treatment should be sought when the diarrhea begins.

## **Lack of Appetite**

People with AIDS often lose their appetite, making the weight loss more dramatic. Sores in the mouth may also develop, making it painful and difficult to swallow.

Studies are showing that good and adequate nutrition really makes a difference in staying healthy with HIV and living longer, but even if foods are available, people often do not want to eat.

## **Fungal Infections**

Fungus is a parasitic—type organism that takes advantage of the body's inability to fight off infections. One of the most common ones is *Candida Albicans*. This can appear in any part of the body but often begins in the mouth with a condition called "oral thrush." *Candida* is usually present in the mouth even when no infection is present, but when the immune system can no longer do its job, the *Candida* begins to grow.

This causes white patches to appear in the mouth and down the throat. It can be very painful and makes swallowing and eating difficult. Treatment is available for this condition but can be very expensive. For oral thrush treatment, oral tablets, which are sucked on or liquid which is swished around in the mouth, is most common. Drugs such as Nystatin oral suspension or Miconazole are frequently used. In severe cases there are drugs which can be given by mouth or by injection which work in the body's system to fight the fungus.

## **Skin Rashes and Infections**

Many different types of rashes can occur as the body's defense system becomes weaker. Brown or white patches on the skin can be a sign of a fungal infection or a more serious condition, Kaposi's sarcoma, which is a form of cancer. Usually the patches with Kaposi's are brown or red and are raised.

Whenever infection is present, the lymph nodes can swell up, as in the case of the story at the beginning of this lesson. The white cells in the blood are part of the defense system—mentioned earlier—which fights off infection. When infection occurs, the white cells increase to fight harder and they “pile up” in the lymph glands, causing the swelling.

## **Feeling Tired all the Time**

All of the above symptoms will cause extreme fatigue. Persons without active symptoms but with a low T—cell count will often experience fatigue. Frequent rest periods are necessary. It is sometimes difficult to keep up with regular household work, gardening or a job due to fatigue.

## **Cough and Tuberculosis**

Just as in the case of the fungus *Candida*, which is present in the body but begins to grow and causes problems when the immune system is weakened, the bacteria which causes tuberculosis (TB) is also often present in the body. This is especially true in areas where TB is very common.

Because HIV/AIDS causes the immune system to be weakened, TB bacteria, if present in the body, often activates. Very frequently, if a person develops AIDS, they will also develop TB. Likewise, if a person is diagnosed with TB, there is reason to suspect that HIV may be present too.

Early symptoms of TB are weight loss, night sweats, and cough. Usually the cough begins to produce sputum and the sputum gets grayish looking and thick and can contain blood. In advanced stages of TB, a person can cough up blood. The weight loss becomes severe and death is not uncommon without treatment. TB can also be found in other parts of the body besides the lungs.

Since early signs of TB are similar to early signs of AIDS and both should be checked for when the above symptoms are present.

Treatment for TB is complicated and takes about nine months to complete. It usually involves at least three but usually four medications, which are expensive. The government sometimes has TB programs that will do the testing and provide the drugs without charge.

It is really important that the treatment be taken and completed, and that family and friends who have been close to the person with TB be checked to be sure that they too have not contracted it.

The TB bacteria is contained in sputum droplets that can go into the air when a person coughs. People who live in close proximity to the person with TB, especially in areas that are poorly ventilated, can be exposed to TB and can actually get TB.

### **It is much easier to get TB from someone than to get HIV.**

Many people who have AIDS actually die from TB because the lungs or other organs are destroyed by the TB bacteria.

## The most common drugs used to treat TB are:

- Isoniazid
- Streptomycin
- Ethambutol
- Pyrazinamide
- Rifampicin

Doses and combinations of these drugs vary from country—to—country. The drugs have to be taken for six to nine months and people often become discouraged and quit taking them or cannot afford to continue the treatment. This has caused resistance to occur to some of the TB drugs.

Some governments have programs that provide TB testing and the medications without charge. It is extremely important that TB is treated even if a person has HIV because the TB can so easily be transmitted to others and can take the lives of those who are not HIV positive.

## HIV Testing is the only way to Know if the Symptoms are HIV/AIDS

All of the symptoms above which have been listed for AIDS can also be symptoms of other diseases. ***The only way to know for sure that a person has HIV or AIDS is to have an HIV test.***

## Treatment/Cure for AIDS

### Scenario for Discussion:

Two brothers talking.

**Samuel** — Look, I'm really sorry that you got this AIDS thing. We'll all be praying for you. But more than that, we've taken up a collection to send you to Bura Bura.

**Lenny** — Bura Bura, why there? That's a two—day bus ride from here.

**Samuel** — Look, I heard people talking at the town meeting the other day. An herbalist has discovered a cure. He has treated over 50 people with a special herb and their symptoms are going away. We want you to go there so you can be cured.

### Questions for Discussion/Consideration:

- What is happening in the scene above?
- Have you heard about cures or vaccine claims in your area?
- How do people respond to these claims?

Many people have claimed to have found a cure for AIDS only to find that, even though it seemed to help people, eventually they developed symptoms again. No one is sure why these things seem to work for a while.

As of the writing of this manual, **there has been no cure for AIDS and no vaccine or medicine that prevents getting it.** Many scientists are working on finding a cure and hopefully one day it will be found.

There are a number of drugs that have been produced that work to prolong a person's life who has HIV. They are called antiretroviral drugs (ART's or ARV's). Antiretroviral drugs prevent the reproduction of the HIV and their goal is to keep the level of HIV in the blood as low as possible, even undetectable. There are three different classes of ART's and they all act in different ways but the end result keeps HIV from reproducing.

Unfortunately these drugs are very expensive and not always readily available in some countries. They do not claim to cure AIDS but do allow a person to live longer and often with no or few symptoms.

Two ART's are being made more available in many countries and these are the ones which help to prevent mother—to—child transmission of HIV. These are AZT and Niverapine.

Many countries are receiving Niverapine free from the manufacturer if certain protocols are met. This means that pregnant mothers can often get the drug without charge. More will be discussed about pregnancy and this drug in the section about HIV and pregnancy.

Some countries are beginning to manufacture ART's which allows for the possibility of providing more drugs to more people. Hopefully, in the not—to— distant future, ART's will be available to the general population who are HIV positive.

## **Prevention of HIV/AIDS**

### **Story**

Sahib is a 55—year old farmer who has lived in the same town all of his life. He is a godly man who has never cheated on his wife and who tries always to do what is right.

About three years ago, Sahib was riding his bike and hit a rock and gashed his head open. Neighbors came running to help and took him to the small hospital in the next town. By the time he got there, he had lost a lot of blood. The doctor said he would have to have a blood transfusion and some of the neighbors volunteered to give him their blood.

He recovered from the accident and was soon back to his work in the fields. But a few months later he began to have diarrhea and lose a lot of weight. Finally he went to the doctor and was told that he had AIDS. No one can understand. His wife has asked him several times if he has been with other women, but he strongly denies it.

### **Questions for Discussion/Consideration:**

- What has happened in the scene above?
- Would you call this man an innocent victim?

- How should ministry to him differ from someone who has received the virus as a result of a sinful act?
- Do things like this happen in your area?

The last lesson talked about how HIV is spread or transmitted from one person to another. Knowing the ways that HIV is transmitted also helps to know how to prevent that from happening.

Since HIV is transmitted by blood, sexual secretions and breast milk, prevention can fall in those three categories.

Since the primary way that HIV is transmitted is by sexual contact, that is where much of prevention emphasis should be placed.

A very popular way of thinking about prevention is by the ABC method:

## **A is for Abstinence**

Abstinence means doing exactly what the scripture says—refraining from sexual contact before marriage. Many young people particularly are engaging in sexual activity with many different people and statistics are showing that some of the most infected people are in the 15 — 24 years of age category.

Children and youth need to hear the message of abstinence over and over again. It should be heard in church, in schools, in the media and anywhere that children and youth are.

Anal sex, often practiced by homosexuals, is also a very high—risk way that HIV can be transmitted. The tissues of the anal tract are fragile and easily torn, making an ideal entry point for HIV when the penis is inserted into the anus.

Oral sex is not as high a risk as vaginal or anal sex but can be a way of transmission if there are any open sores or open areas in the mouth.

## **B is be Faithful**

Faithfulness in marriage is also a biblical mandate. The bible clearly says to not commit adultery. Men and women who are unfaithful and have sex with people other than their spouses can bring the HIV home and infect one another. The sad thing is that babies born to an infected mother can also get AIDS.

**Premarital HIV Testing**—Premarital testing for couples planning to marry is a very responsible thing to do. Even if the couple decides to get married, if one of them tests positive, they can make informed decisions about protected sex and pregnancy. Protected sex would mean using condoms and if pregnancy does occur and the wife is positive, the couple can seek ART therapy to prevent transmission to the baby. Without knowing their status, they cannot make informed decisions.

## C is for Condoms

This manual is not promoting the use of condoms for safe sex. It has already been stated that condoms are not 100% safe and any risk is too great a risk. Sometimes condom use gives a false sense of security and people feel that they can have premarital or extramarital sex without risk as long as they use them.

Abstinence and faithfulness are the preferred methods of preventing the sexual transmission of HIV.

However, as in the case stated earlier where one partner in a marriage is found to be HIV positive, condoms should be used to try to prevent the spread of HIV to the spouse. Used correctly latex condoms of good quality will prevent the transmission of HIV.

Also, if young people are not following Christ and not living according to biblical standards, then the use of condoms is better than no protection at all.

## Needles, Dental and Medical Instruments, Razor Blades

Any instrument which touches the blood of one person and then is used on another person has the potential for transmitting HIV. Boiling the instruments or needles will kill the virus. Soaking instruments in a 1 to 99 solution (1/4 cup of bleach in one gallon of water) will kill the virus also. Solutions of 1 to 10 can be used for smaller surfaces. Surfaces and linens that have had blood on them can also be soaked or cleansed with a bleach solution. Bleach causes corrosion of metal so is not the best chemical to use on instruments, but if nothing else is available, it will inactivate the virus.

It is a good practice to inquire about how sterilization is done before undergoing medical or dental procedures.

**An HIV in a drop of blood can remain alive for up to fifteen days in laboratory tests** though this depends to a great extent on how many virus are in the drop of blood. Usually when a drop of blood begins to dry, it starts to destroy the virus and the more common amount of time the virus survives is one to two hours. The small opening (bevel) of a needle on a syringe can harbor a drop of blood and keep the virus alive for many hours. This is why there is so much HIV transmission among intravenous drug users who share needles.

This becomes significant information when caring for someone with HIV. Handling laundry soiled with blood can be dangerous if the handler has an open sore that comes in contact with the blood on the laundry. Transmissions which occur this way are very rare, however.

## Blood Transfusions

Many countries have the ability to screen blood for HIV and other diseases such as hepatitis and malaria before it is used. But not all laboratories or hospitals yet have that capability. If at all possible, it is best to have someone known to be HIV negative donate blood and to avoid receiving a transfusion unless it is a matter of life or death.

In some countries, pregnant women who have been told they may need a cesarean section for delivery or who have had excessive blood loss in the past when delivering, may want to donate their own blood and have it frozen to be used should need arise during delivery. Not all facilities have this capability but if a mother has been tested and knows she is HIV negative, she may not wish to risk receiving blood that has not been screened. It is always good to ask if HIV screening is done on blood before it is transfused.

## **Mother—to—child Transmission — Prevention during Pregnancy and Breast—feeding**

If a couple knows that the wife is HIV positive, they may decide that they should not have children because of the risk of transmitting the virus to the baby.

If a woman is pregnant and lives in an area where AIDS is very common, it is wise to have an HIV test. This will help her (and hopefully her husband) make an informed decision about taking the antiretroviral drugs, if available, to reduce the risk of spreading the virus to the baby.

Some areas of the world also practice vaginal disinfection during the birth process. This is the washing of the vagina with a solution which will kill HIV that may be in the blood of the vaginal canal. This along with ART helps reduce the risk of passing the infection to the baby. Most of the mother—to—child transmission takes place during the birth process itself.

It will also help in decisions about breast—feeding. Remember that there is about a 15% chance that the virus will be passed to the baby by breast—feeding.

If artificial feeding is not feasible it is strongly recommended that “exclusive breast—feeding” be done for the first six months of the baby’s life. Exclusive means that no other food or drink be added to the baby’s diet. Rather the mother gives only breast milk.

The reason for this is that consumption of cow’s milk, allergic reactions to other foods and infectious illnesses can be introduced through food and water and these can damage the infant’s digestive system, making it easier for the virus to enter the baby’s bloodstream thereby increasing the risk of getting HIV from breast—feeding.

### **Scenario for Discussion/Consideration:**

Pastor speaking with Richard and Martha who are engaged to be married.

**Pastor** — Well you two seem to be really in love. I’m glad that you are both serving the Lord and I would be happy to marry you. But there is one thing I must ask you to do before we set the wedding date.

**Richard** — Sure pastor, we’ll do anything.

**Pastor** — Well, I’d like you to both have an HIV test.

Richard and Martha looking very stunned

**Martha** — But pastor, why do we need to do that? We have never had sex with anyone else, right Richard? Richard? *Richard hangs his head and doesn't say anything.*

### Questions for Discussion/Reflection:

- What is happening in the above scene?
- If you were a pastor, would you be likely to give the same advice?
- Why or why not?
- What would knowing your diagnosis mean to an engaged couple?
- Is pre—marital testing common in your area?

## HIV Testing as a Prevention Strategy

An HIV (Human Immunodeficiency Virus) test is one that looks for the presence of the HIV virus or the antibodies of the HIV virus in the blood or saliva of someone who may have been infected with the virus.

The tests available in most parts of the world do not detect the actual virus but a copy of the virus that the body makes which is called an “antibody.” The body makes this copy to remember this “invader,” should it come to the body again.

The World Health Organization and United Nations have concluded the following regarding people who know their HIV status:

- They are more likely to practice safer sexual behaviors.
- It is also possible that a married couple who learns that one or both are HIV positive may decide not to have children.
- A pregnant mother who learns that she is HIV positive may decide to take anti—AIDS drugs to prevent passing the HIV virus to her baby during the birth process.
- They improve their health status through early access to medical care.
- They receive emotional support as the stages of illness progress.
- They prepare in advance for the welfare of their families.
- They prepare themselves spiritually for eventual death.

Many countries of the world now use an HIV test called the “rapid test.” Unlike the older types, which took about a week to get results, these can give a result in as little as 10 minutes.

It is important that counseling be given along with the testing. Most testing facilities try to offer both pre and post—test counseling. This helps in educating people about AIDS and AIDS transmission (an excellent use of the *AIDS Booklet—What you Should Know*). This training manual provides additional information that the trainer may need to know when teaching the booklet to others. The counseling also helps to prepare people for a possible positive HIV result. It is difficult to have much impact after a positive test result is given.

It also provides an opportunity to understand about the “window period.” The window period refers to the fact that when the HIV enters the body, the body makes a copy of it called an

antibody, which is what an HIV test looks for and finds. However, it can take from three to six months for the antibodies to be made. Therefore, if a person has a negative HIV test result but has had some risk behavior within the last six months, it is necessary that they have another test to make sure that the antibody wasn't missed during the "window" period.

When babies are born to an HIV positive mother they often will test positive on an antibody test for HIV. This does not mean that the baby is HIV positive because it may be only the antibodies and not the virus was transferred to the baby. By the age of 15 to 18 months naturally transferred antibodies disappear. So a baby which tests positive at birth should be retested at 18 months. If at that point there is a positive test, the baby is then thought to be truly positive. If the baby tests negative at birth but is breast fed by an HIV positive mother, the baby should be retested in six to nine months to determine if the virus was transmitted through breast milk.

HIV voluntary counseling and testing are very important. People should be encouraged to be tested from all levels of society. It is felt that if people know their status, they will be more responsible and not tend to spread it to others if positive and take steps to avoid getting it if negative.

More information on this subject will be given later in the course. For more in—depth information about testing and counseling please refer to the manual, *HIV Testing and Counseling—A guide to train workers in voluntary testing and counseling skills for HIV/AIDS* (Butrin, 2003).

## The Stigma of HIV/AIDS

### Scenario for Discussion:

Two pregnant women talking at a prenatal clinic.

**Lisa** — Boy, my back is killing me. I wish we didn't have to sit through this lecture about HIV.

**Naomi** — Well, I heard it the last time I was here and I've been thinking about getting the test. I have a lot of reason to think I could have it.

**Lisa** — Are you serious? You're crazy if you get that test! What if you do have it and your husband or family finds out? You can't trust those lab people. They'll be sure to tell someone and then you'll get kicked out and then what will you do? Not me, boy I'm not going to find out. If I have it, I have it, but I don't want to know.

The above role—play points out some of the problems associated with stigma and discrimination. Many people are so fearful of the idea of a terminal illness like AIDS that they would rather not know that they have it. Therefore stigma itself may interfere with prevention strategies, such as testing.

Even with the risk of transmitting the virus to the baby, the risk of being homeless, penniless and rejected by family and friends may outweigh the concern for the child.

A mother may know that she will not be able to support the child if she loses her husband and home and therefore makes the decision that she thinks best.

The dilemma points to the importance of the role of trainers, communities, and especially churches

in helping to “de—stigmatize” the AIDS issue. When there is silence from the church or pulpit, the silence contributes to the stigmatization.

The more the issues and dilemmas of HIV/AIDS are discussed, the more free people will feel to seek testing and to seek advice and spiritual counsel.

For a pregnant mother to make a decision to be tested and to take steps to protect her unborn child requires extreme courage and support. It is a difficult thing to do alone.

It is hoped that the church will begin to take a lead in helping to open dialogue about AIDS and to encourage members to be tested. It is also necessary to discourage rejection and discrimination, which often happens within the church membership.

The church, the house of God can and should be a “safe harbor” for those who are HIV positive.

### **Questions for Reflection:**

1. If you thought you might have been exposed to HIV, how likely would it be that you would get tested? Why or why not?
2. Why do you think that some people don't want to know their HIV status?
3. If you knew that either you or your spouse were HIV positive, what would you do about pregnancy? Why?
4. What do you know about the screening of blood used in transfusions in your area? How might you find out?
5. How could a message of hope in Christ be woven into a message about the importance of HIV testing?
6. If you were HIV positive, what would you want to know?
7. If you were HIV positive, where would you go for help? Why?
8. If you were HIV positive, who would you tell? Why?

## Unit 2

# Building a Framework for the Church's Response

## Lesson Four What is the Biblical/Christian Response to the AIDS epidemic?

### Lesson Objectives

At the completion of this lesson students will be able to:

1. Critically assess reasons for the church's early reluctance to participate in HIV/AIDS outreach and determine whether that reluctance remains in the student's local context
2. Evaluate scriptural mandates to the believer and the church regarding those who are "suffering and "in need"
3. Evaluate the scriptural context of compassion and evaluate its usefulness as a template for Christian response to the HIV crisis.
4. Defend the advantage of a Pentecostal approach in HIV/AIDS outreach and outline how this approach may differ from that of a non—Pentecostal outreach
5. Critically evaluate the term "spiritual readiness" particularly as it applies to a person facing imminent death
6. Outline key components to effective spiritual ministry to persons dying with AIDS or other terminal illness

### Scenario for Discussion/Consideration:

Two young men talking.

**Chan** — Paul, I'm so afraid. I already feel like I'm half dead. It seems like I'm losing weight every day and every night when I go to sleep, I wonder if I will die. I feel absolutely hopeless. Nothing will help me now; I'm as good as dead.

**Paul** — Chan, it must be terrible for you. I can't begin to understand how you feel. I don't want to offer you something that may sound phony, but I do want you to know that there is hope in the middle of this terrible situation.

**Chan** — Hope? How can there be hope when I know I'm going to die?

**Paul** — Let me tell you a story about a man named Jesus...

## Questions for Discussion/Reflection:

- What do you see happening in this scene?
- Have you ever encountered something similar?
- How do you see evangelism and the AIDS crisis intersecting?
- Do you see this type of thing happening in your area?

## Introduction

The AIDS crisis, which began in the early 80's has been around for a long time now. Epidemics usually appear, run their course, and disappear again. One hears about outbreaks of the deadly Ebola virus, but only sporadically. It comes, kills a few people, and seems to disappear again. The AIDS crisis is different. It is not disappearing, but rather it is spreading and getting worse as time goes on. It is no longer confined primarily to the Africa continent, but is now being experienced the world over.

No one knows for sure where the virus came from, though there is speculation that it originated as a disease found in chimpanzees and mutated to become what we now know as HIV—Human Immunodeficiency Virus. No one is quite sure how it began to be spread to humans.

It began to be seen in Haiti among homosexuals and hemophiliacs. Hemophiliacs are persons who have a blood disorder, which causes a lack of clotting and excessive bleeding. Most people who have this disorder receive either transfusions or products that have components of blood in them. Homosexuals in the US began to show signs of the infection and then it began to be diagnosed in Africa.

In the twenty plus years since its beginning, the virus has spread either from person to person or has been carried in blood products, literally around the world.

## The Absence of the Church in the Crisis

As the AIDS epidemic began to be known and understood, groups of people began to step forward to lend a helping hand. Notably, the church was, for the most part, not among those who took a lead in offering service and care to persons with AIDS.

**Judgmental Attitudes** — The reasons for this hesitancy are many, but probably the most common reason for a seeming lack of concern stemmed from a judgmental attitude. Early cases of AIDS were seen among homosexuals. Since this is a lifestyle condemned by Evangelicals, and often detested by Christians, the inclination to be at the forefront of offering assistance was dim if not non—existent.

Christian churchgoers were known to say such things as, “the homosexuals are getting what they deserve”, or “this is punishment from God, why should we do anything to help?” (Butrin, 1997) Persons who were in the church and who found out they were HIV positive, also often found that they had to leave the church when they decided to disclose their diagnosis. One Zambian woman said that when she came forward with her HIV positive status in her church, she was told she

could come, but would have to sit outside the church. She was not welcome inside (Conversation between Butrin and Zambian woman, 2003).

In the early days of the epidemic, the church did not prove to be a safe refuge. Deliberate shunning and stigmatization occurred. One family, known by the author of this course, cared for and buried their homosexual son without ever disclosing to anyone in the church that he was sick or that he died from AIDS. They feared that they would be rejected and scorned by their church “family.”

**Fear** — Fear is another factor that held people back from reaching out. Before the facts about AIDS were well known, people were concerned that they could get AIDS if they were around someone who had it. Many were convinced that the “real facts” were not being disclosed and that the ways of transmitting AIDS was being hidden. Whether an excuse or not, many people, out of fear, simply turned their backs on people who were HIV positive and refused to participate in outreach to them.

Sadly, there were thousands of people dying without a knowledge of Christ. Many perhaps, were searching for spiritual answers knowing that they were facing eternity, but judgment, stigma, fear and denial kept the Good News from reaching them in time.

What should the response of the Christian and the church be to this epidemic? What is the mandate to believers in regard to reaching out to those who are suffering—even if that suffering stems from sin?

## **The Model of Jesus**

The life of Jesus, while here on earth, gives a model for Christian response to human need—regardless of the origin and regardless of the need. The model of Jesus begins with love.

Time and again Jesus reached out to touch those in need. The bible is full of passages that convey a personal responsibility to minister as Jesus did. Mark 1:41 (NIV) describes the compassion that Jesus felt as He observed someone in pain. “Filled with compassion,” Mark states, “He reached out and touched the man”(a leper). Leprosy has at times been compared to HIV/AIDS in that people are fearful of contracting it, are unwilling at times to come close or touch someone who is HIV positive, stigma is attached to it, and loneliness and isolation are the most probable outcomes. What Jesus did in touching and healing the leper was remarkable for the day in which he lived. Lepers were not allowed to approach the general public. They had to identify themselves by crying, “unclean, unclean” if they were near anyone who was not a leper. They were social outcasts, feared by most and repulsive to many. It would have been unthinkable in that day for a person to touch a leper. Yet Jesus not only touched him, but healed him completely.

Jesus did not reserve His ministry to those who were like Him or believed as He did. He reached out to social outcasts such as lepers and prostitutes—to the rich, the poor and to sinners. It was often the most unacceptable and unworthy who received His gracious and compassionate touch.

In Matthew 9:36 (NIV) the account is given of Jesus as He looked over a crowd of people. He saw “all manner of sickness and disease.” Jesus lived in a day when medical care would have been minimal, where people intermarried, and where there were overwhelming physical conditions that confronted Him. He also observed people who had no spiritual foundation and He was

“moved with compassion.” He described them as “helpless and harassed, like sheep without a shepherd.”

The account of His contact with the woman of Samaria in John 4 is very apropos to the way in which Jesus dealt with those who were stigmatized. Jesus’ very association with the Samaritan woman was scandalous in those days. Jews and Samaritans did not even speak to each other. This woman was not only of an “untouchable ethnic background,” but was also living in sin with a man to whom she was not married. Jesus took time to talk to her about her life and the “living water” that He had to offer her. Luke 4:39 says that many Samaritans believed in Him because of the testimony of this Samaritan woman.

With the above acts of compassion and the touching of both body and spirit, Jesus gives a beautiful model for the believer and the church:

- There if no one who is untouchable to Christ and therefore to the believer
- Compassion is the expected response of a believer who sees need
- Compassion is not passive but results in action
- Touching a person in need can take many forms but is personal and involved
- Touching a person in need can bring healing in different forms and in different ways, physically, emotionally and spiritually

## **The Cross and AIDS**

The life of Jesus portrays a life of compassion and love. The ultimate love was shown on the cross as Christ gave His life for the redemption of sin. His life was given for “all sinners.” There was no classification of sin, no one sin considered to be worth the cross with the exclusion of others. The cross experience erases the question of the why or what of sin. He paid it all with His life.

The cross was also a place where healing of sickness and suffering became possible. Luke 22:19, “...this is my body given for you....” Isaiah 53:5 “....with His stripes we are healed”.

The life of Jesus, His compassion for not only the sin of humankind, but for physical and emotional needs as well, gives a model for love, compassion and ministry to the whole person. Often Jesus combined salvation and healing together. When speaking with the Samaritan woman He offered emotional help included in His Living Water.

Compassion shaped the life of Jesus. Through his compassionate acts of caring and love, He prepared hearts to receive Him as Savior. Each time the scripture records Jesus being moved with compassion, it resulted in the meeting of human need. Jesus responded to the sea of hurt and need that surrounded Him—the sick, the blind, the beggars, the widows, the lepers. He experienced their pain in His heart. His life was compassion in action (Kilbourn, 2002).

After portraying a model of love and compassion, Jesus sent out His followers to “do likewise” (Mark 16:15—19). The early church shared their resources with the needy and cared for the widows and orphans (Acts 4:34—35).

Henri Nouwen in *Compassion: A reflection on the Christian life* says,

“Compassion is hard work; it is crying with those in pain it is tending the wounds of the poor

and caring for their lives it is defending the weak and indignantly accusing those who violate their humanity, it is joining the oppressed in their struggle for justice, it is pleading for help with all possible means, from any person who has ears to hear and eyes to see. In short, it is a willingness to lay down our lives for our friends.”

He goes on to say,

“Compassion asks us to go where it hurts, to enter into places of pain, to share in brokenness, fear, confusion and anguish. Compassion challenges us to cry out with those in misery, to mourn with those who are lonely, to weep with those in tears. Compassion requires us to be weak with the weak, vulnerable with the vulnerable, powerless with the powerless” (Nouwen, McNeil & Morrison, 1982).

James 2:14—16 instructs believers to take care of those in need. “What good is it my brother if a man claims to have faith but has no deeds?” (vs. 14) “Suppose a brother or sister is without clothes and daily food. If one of you says to him, ‘go I wish you well: keep warm and well fed,’ but does nothing about his physical needs, what good is it?” (vs.17)

Clearly Jesus was admonishing believers to follow His example. There was no question that the Christian mandate was to combine faith and works, meeting spiritual, physical and emotional needs of those who were in need.

Persons living and dying with AIDS are in great need of the compassion and love modeled by Jesus. If Jesus were walking the earth today and encountered an HIV positive person, He would not be concerned with how the disease was contracted. Rather His concern would be for the needs of that individual, body and soul.

The question of how a person contracted AIDS is not the question. Some, such as babies and children, spouses who received the virus from an unfaithful partner, those who contracted the virus from an infected instrument or blood supply, are victims. Others, because of immorality and a lifestyle that put them at risk, are also victims because they are destined to die, without a Divine miracle. Regardless of the cause, both groups are people needing Jesus in their lives.

They may be lonely, isolated, searching for answers, in need of peace, love, and hope, all of which can come from a relationship with Jesus and fellowship with those who truly love and care for them.

The mandate of believers and the church is to love our neighbor as ourselves. In Luke 10:30—37, (NIV), the story of the Good Samaritan presents a portrait of how Jesus would expect the believer to respond to a person with HIV/AIDS:

In reply Jesus said: “A man was going down from Jerusalem to Jericho, when he fell into the hands of robbers. They stripped him of his clothes, beat him and went away, leaving him half dead. 31 A priest happened to be going down the same road, and when he saw the man, he passed by on the other side. 32 So too, a Levite, when he came to the place and saw him, passed by on the other side. 33 But a Samaritan, as he traveled, came where the man was; and when he saw him, he took pity on him. 34 He went to him and bandaged his wounds, pouring on oil and wine. Then he put the man on his own donkey, took him to an inn and took care of him. 35 The next day he took out two silver coins and

gave them to the innkeeper. 'Look after him,' he said, 'and when I return, I will reimburse you for any extra expense you may have.'

36 "Which of these three do you think was a neighbor to the man who fell into the hands of robbers?"

37 The expert in the law replied, "The one who had mercy on him."

**Jesus told him, "Go and do likewise."**

The scripture is clear then that the believers who are the church, can do nothing less than embrace, nurture, love and accept those who are headed for eternity because of HIV/AIDS, loving them until their final breath.

**The Church Today** — In more recent years of the AIDS crisis, the church has begun to realize its responsibility in this crisis. Many churches are now actively developing programs of outreach to those in need. More notably however, many churches are welcoming HIV positive individuals into their loving arms and giving personal assistance until death.

The next lessons will look at practical ways in which the church can be involved in the greatest medical emergency and greatest human tragedy of all time.

## **The Pentecostal Distinctive in Outreach Ministries**

No one would deny that one need not be Christian or Pentecostal to feel compassion. Most would agree that non—Christians can be moved deeply by the needs which they see and can undertake actions which greatly assist in the reduction or alleviation of the physical or immediate cause of the suffering.

However, when a view of person encompasses that of body, emotion and spirit, then the work of bringing change and healing to a situation goes beyond the obvious and immediate need, a much harder task.

When a person filled with the love and compassion of Christ and filled with the Holy Spirit reaches out to another's need, there is "heart" work going on. One is vitally concerned with every aspect of the individual's need and therefore with the guidance of the Holy Spirit can reach more deeply into a person's life to address emotional and spiritual needs. Hope is the main ingredient to healing and true hope can only be found as one begins a relationship with Jesus Christ.

Hopelessness, a condition often felt by those with a terminal illness such as AIDS, cannot be healed by the meeting of basic needs, though that is often the initial entry point to a person's heart. Evangelism alone, which leaves gaping physical need unmet, also does not complete the task.

With ministrations of care, infused with the work of the Holy Spirit in the givers' lives, a compassionate touch becomes one that brings heart healing which ultimately restores hope.

Empowerment is a good word and one that is often used when describing principles of development. But in the Christian realm, it is much more than increasing one's capacity to help themselves, though so needed. Empowerment to the Pentecostal, builds the capacity of the human heart to feel the ministration of the holy spirit in the face of a relationship with Christ. It can be thought

of as a direct infusion of hope as the reality of eternal life comes into focus and the reality of abundant life on earth — even in the midst of suffering, is somehow grasped

### **Scenario for Discussion:**

**Caregiver newly assigned to a patient** — I'm so glad I could come and spend time with you today. I know you are probably wondering what will happen to you and I'm here to help you get saved and have the certainty that you will go to heaven.

**Patient** — I don't know what you mean by "saved," but if you are talking about God, I don't want any part of it. What kind of God would allow a thing like AIDS to come into the world? And what kind of a God would let me get it? Forget about trying to tell me about a loving God.

**Caregiver** — Oh, I know you are upset right now, but you need to know the truth. God does love you and the only way you can get to heaven is by accepting him as your personal savior. You don't have a lot of time so you need to get this taken care of as soon as possible.

### **Questions for Discussion/Reflection:**

- What is happening in the scene above?
- What is the patient feeling?
- How do you think the patient feels about the caregiver's comments?
- What would you say to this patient?

## **Offering Spiritual Care**

Without question, people who are approaching death, or even facing the possibility of death when aware of HIV positive status, regardless of their religious persuasion or beliefs, will face thoughts of "what will happen after they die." Though they may not seem ready to discuss those issues, there will certainly be inward thoughts about one's final destiny.

Though a religious figure such as a pastor or priest may be a part of the care team, it may be the person offering daily comfort or physical care who will have most opportunity for these profound and intense discussions. There is no formula for who should offer spiritual care, or how it should be offered, but there are guidelines which will assist in more effective ministry at this critical time.

## **Guidelines for the spiritual companion**

It is important for a spiritual companion, be it the caregiver or another, to carefully examine his or her own beliefs and why they believe them. Prejudice against a certain belief or lifestyle of the persons cared for can cause a barrier for effective care and unconditional acceptance of the person being cared for.

**Readiness to discuss spiritual things** — Sometimes with fervor to see someone come into a relationship with Christ before they pass away, the caregiver, pastor or helper may try to force or hurry a discussion about spiritual matters before a person is really ready to have that discussion. Or it may be that the ill person would feel more comfortable with someone other than the person trying to have the conversation. Ultimately, those who have faith in Jesus Christ do wish for others to share that faith, but sensitivity and timing and the readiness of the person to discuss these issues need to be kept in focus.

## Keys to effective ministry

- Come to terms with your own theology of suffering and healing. Examine the suffering of Job (Job 1—42); Jesus (Matthew 26:38—46); and Paul (2 Corinthians 11—12).
- Recognize that a miracle of healing can be present or eternal. We are invited to anoint with oil and pray for the sick (James 5:4—16). At the same time Paul encourages us to seek eternal healing, which is eternal life (2 Corinthians 5:2 and Philippians 1:20—21).
- If the patient is not a Christian, practice loving the sinner regardless of his or her lifestyle. Jesus modeled this to us when He ministered to the thief on the cross (Luke 23:40—43); the woman who worked as a prostitute (Luke 7:36—48); and the adulteress woman (John 4:1—26).
- Seek appropriate timing for conversations that deal with salvation and spirituality. Jesus waited at the door, allowing the individual on the other side of the door to choose the time that was right for salvation (Revelation 3:20).
- Provide assurance that God is present even when there is pain and suffering.
- Share difficult situations with others. You will not be able to minister effectively to every patient. Personalities, backgrounds, and genders sometimes interfere with ministry. Know your limitations, and call on others to help when necessary.

Some questions that may help a person to think about and even discuss their feelings about such matters may be as follows:

- Are you comfortable talking about spiritual issues?
- What provides meaning for you?
- What is your source of strength?
- What do you think is going to happen to you?
- What are you afraid of?
- What role does God play in your life?

Some persons feel relief in being able to speak about these matters. For others it's an admission that their life is going to end and they find it very frightening. They also may feel more comfortable having a pastor or spiritual leader engaged in these discussions and the caregiver may be able to arrange for that to occur.

## God's love extended through the caregiver

Some people, including perhaps the person being cared for, have had really difficult and hard lives. They may have known very little love or care in their lives and you, the caregiver, may be the first person to show kindness, gentleness and love. This may be the first glimpse of God's love, through you, that this person may have experienced. If the caregiver can realize what a special gift it is to be God's hand of grace, mercy, compassion and love for this person, it will make the burden of care lighter. The scripture in Matthew 11 says, "Come to me, all you who are weary and burdened, and I will give you rest."

Our goal in being beside the person whose life is ending is to care for them, to love them, to represent Christ to them. We want to offer hope and eternal hope may be all that is left. Some will receive that divine message of hope and others will not. But our relationship, the way in which we care for them, may be more important in bringing that hope than any words we initially say.

Be patient and pray constantly that God will allow us the privilege of introducing the ill person to Christ, but do not dismay if the message is rejected. Our reason for being with this person remains. Whether they accept or reject the message of God's love, our mission continues to be to serve their needs to the end.

### Questions for Reflection:

- What is your personal attitude toward people with AIDS?
- Have you ever worried that you might contract AIDS if you were in close contact with someone who has it?
- How do you feel about your children or family being in contact with persons with AIDS?
- As a Christian, do you feel you have any personal responsibility in this crisis? What would that entail?
- If you were a pastor of a church, what would you do to encourage a ministry to those with AIDS?
- How would you respond to someone who says that they are getting what they deserve?
- Do you agree with the section above on a Pentecostal or Holy Spirit distinctive in compassion outreach?
- What would your spiritual needs be if you were dying?
- Who would you want to be by your side near the end of your life besides your family? Why?
- What would give you the most comfort as you face death? Why?
- If you were a pastor visiting someone who was dying but was not a believer, what approach would you take? Why?
- What would you do if you encountered a person who was really angry with God?



# Lesson Five

## Principles of Church/Community Development

### Lesson Objectives

At the completion of this lesson students will be able to:

1. Critically evaluate the advantages of church—based HIV/AIDS outreach
2. Develop a step—by—step outline for effective church—based HIV/AIDS outreach
3. Interpret the meaning of “community” in the context of the student’s cultural context
4. Evaluate the appropriateness of transformational development strategies in HIV/AIDS outreach in the local/national context
5. Outline the basic components of relief and development strategies and assess the most effective use of both in HIV/AIDS outreach
6. Describe key components of the Community Health Evangelism (CHE) program
7. Evaluate the main participants in the CHE model and assess the effectiveness of this type of model to the student’s own local context
8. Critically assess the various models of CHE (church, family, community) and evaluate their use in the student’s context
9. Determine the appropriateness of CHE as a framework for HIV/AIDS outreach in the local/national context.

### River Scenario for Discussion/Consideration:

(Two lines are put on opposite ends of an imaginary riverbank. Stepping stones, and paper or cardboard, are placed at reaching distance along the way)

Two people stand talking at the edge of the river:

**First** — Boy, I sure wish we could get across the river. Just think, we could go to the market there and get the things we can’t get over here. And we could probably sell our things there too and get some money.

**Second** — Yeah, it would be great, but we know it’s impossible. That river is full of piranhas and crocodiles. Man, it would be life—threatening to go across there. I can’t swim either.

**Third person walks up** — Hey, how’s it going? What are you doing here at the bank? Are you going across?

**First** — No way, we can’t get across. Nobody goes across this river.

**Third** — I do—I go across all the time. In fact I’m going now.

**Second** — No way, how would you do that? Do you have a boat or something?

**Third** — No I walk across. Would you like to go with me?

**First** — Yes! Well, no actually. I’d be scared to death—I don’t think its possible.

**Third** — Sure it is; look since you are scared, I’ll carry you. Just hop on my back here and we’ll go.

Lots of nervous chatter, scared. **Third carries person to middle but sets him or her down saying** — wow, you are heavier than I thought. I really can’t take you any further. I’m going to have to leave you here.

**First** — What! Wait, you can’t leave me here. I don’t swim, I’m scared, I’m not ready. Please put me on your back and carry me again.

**Third** — Sorry, but I really can’t take any more time with this. I have to go. Just follow the stones under the water. You can make it. Goes on across the river intending to leave.

### **Questions for Discussion/Reflection:**

- What is happening in the scene above?
- What is represented by the man trying to carry the other man?
- What happened to the carrier?
- Who was helped in the process of carrying?
- When the first person learned how to do the crossing, what happened?
- How many people knew how to cross by the end of the story?
- How might this scene apply to relief and development?

## **The Advantages of Church—based Outreach**

The previous lesson, The Biblical Response to the HIV/AIDS Crisis, made it clear that the church is mandated by scripture and the love and compassion of Jesus to be at the forefront of outreach and response to the HIV/AIDS epidemic.

Many churches of the world are forced to confront the situation as many church members are dying and church families are becoming extinct. However, in some regions of the world AIDS is not yet in epidemic proportions and not being experienced by many in the church world.

As it is not a front line issue for these churches, nothing is being done to address the subject of AIDS. In so many continents and nations of the world, the epidemic is just beginning to take on significance and it is at this time and even prior to this, that there is opportunity to turn the tide of its spread. It is always the “time” to deal with this problem, whether it seems to be prevalent or not. If it exists at all in a given country, it has the potential for becoming a large and overwhelming problem.

The church can and should be at the forefront of beginning to flood its young people and members with awareness information. The church should also be at the forefront in involving the community in AIDS outreach and partnering with those who are already doing something.

The church has a great deal to offer to the crisis:

- It meets regularly and frequently with its members. That gives opportunity for regular, consistent and repetitive counsel and instruction regarding AIDS.
- The church should be an organism of compassion to the community of which it is a part. A loving and caring church would be moved to reach out because of the compassion and love of Christ in the hearts of the believers. This should be one of the greatest motivators for the church's involvement — not additional members, not only evangelism opportunities, but because the church cares.
- It brings the spiritual component to any given outreach.. If the church is truly concerned about the salvation of the community members of which it is a part, then the AIDS crisis presents multiple opportunities for touching people's lives for eternity. This is incredibly important in light of the many who are on their way to death as a result of AIDS.
- The church is usually respected by the community of which it is a part. This brings credibility to any message being sent about HIV/AIDS and any program outreach to assist in the crisis.

## Steps in Beginning an AIDS Outreach

**Step 1 — Prayer**— Individual and corporate prayer is the first step in an HIV/AIDS outreach. Praying together as a church and individually for:

- direction from the Lord
- a passion and burden to help those in need
- an anointing on whatever is undertaken and
- the provision of energy and resources to effectively reach out

**Step 2 — Group Dialogue** — What does the group see as most important? Why? What could be done? How could it be accomplished?

**Step 3 — Participatory Needs/Assets Assessment** — In order to help the group dialogue continue, a needs/assets assessment can be done by the group and others who might be enlisted to help. Many examples of this exist—a sample can be found in the appendix of the HealthCare Ministries HIV/AIDS Training Manual (Butrin, 2004) as well as websites.

**Needs** — The purpose of a needs assessment is to find out what the greatest needs of a specific community are. This may be the community which is near to the church, a small village community, or a specific area of a city.

If the focus is AIDS, the assessment may be tailored to find out information about the existence of AIDS, how big a problem it is, what the main issues involved with the disease are in that particular community and what is already being done about it. The last is an important question as some other church or group may already be doing it.

**Assets** — Another part of the assessment is to determine the strengths or assets of the church and community to respond. This part of the assessment focuses on resources, strengths, abilities, capacities and talents that already exist both in the community and the church. It is very helpful to compare the needs with the assets to determine if the planned outreach is likely to be able to succeed. It is also encouraging to be able to identify the strengths and assets and often gives the impetus needed to know that something “can be done”.

**Step 4 — Mapping or Diagramming the Results** — Once an assessment has been done, it may be helpful to the group to make a drawing or diagram of the area that has been surveyed and place the most important findings on it.

**Step 5 — Deciding on a Plan of Action** — After compiling the information, the group can then work together to decide what part the church will play in helping to meet the needs. Perhaps the assessment and the mapping will help demonstrate the priority needs in the community and/or the areas that are not being dealt with by other agencies.

Writing a purpose statement and objectives of the outreach is an important way to clearly define what is being done and what the hoped for outcomes will be. It is important to incorporate a spiritual component into the objectives so that the church will see “whole person” ministry being undertaken.

**Step 6 — Budget Planning** — Once there is a proposed plan and the group is in agreement about what is to be done, the next very important step is putting together the proposed costs of the outreach. It may be advisable to bring in an accounting person or someone who can assist with this process to make sure that “hidden” costs are thought through. A budget should be projected for the assumed length of the project. For most AIDS initiatives one needs to think long term and should probably have a budget that can project five years.

**Step 7 — Sustainability Decisions** —The above plan of action will need to include ways in which the outreach can be funded and sustained financially and with human resources (Some of this information will have been gathered in the Asset assessment). This may be the most difficult part of the planning process but also the most important part. In some cases outside organizations may be able to provide some funding, but the most sustainable projects are those which have a firm plan to be able to generate funds, should outside funding not be available or be limited in the time it is available. The group will need to think through ways of generating income—offerings, micro business, partnering with local entities offering varied types of donations or funds, grant writing, etc.

Sustainability does not only apply to funds but also to human resources. Is the program that is decided upon dependent on volunteerism and can that be sustained? Many programs begin enthusiastically but go awry when volunteers become weary of the load they have undertaken or become sick themselves. Some type of commitment from persons who say they will volunteer will be important.

**Step 8 — Evaluation Strategies** — Every good project or outreach builds in a way to evaluate what is being done and to determine if it is doing what it set out to do. In the plan of action section, a purpose statement and objectives were referred to. These should be written in

such a way that they are measurable. In other words, six months after the project begins, can the group look back to the objectives and evaluate whether they are being accomplished? The ways in which evaluation will be carried out should be clearly stated. In large projects which involve outside funds, this will almost always be a requirement of the donors. Persons who specialize in evaluation strategies might be brought in to consult with the church in the early stages of the program design.

## Defining Community

The task of the church has always been to impact the community in which one resides with the gospel. Its goal is to touch the lives of people with the reality of Jesus. Most churches try to draw people from the community into their congregations and do this by door—to—door evangelism, visitation of neighborhoods, street ministries, campaigns, special services and many other methods.

The focus of this section is to see how the church might break down the walls of its structure and become a transforming part of the community of which it is a part. A model of transformational development will be introduced, entitled Community Health Evangelism (CHE). As will be seen, CHE becomes an excellent template for any type of HIV/AIDS outreach while at the same time, becomes an evangelism extension of the local church.

For the sake of this model, community is defined as “a group of people who live in the same geographic area, hold many things in common, have a sense of unity and belonging and know each other” (Rowland, 2001, p 72). There are many “sub—communities” within a larger community, such as a church group, prostitutes, factory workers, etc. People in communities do not always know each other, but this model works best if the group being addressed is not too large—usually under 5000 members or residents in the targeted community.

## Transformational Development

Before proceeding with the introduction of the Community Health Evangelism model, it is necessary to understand the differences between relief and development.

**Relief** — Often when a church or any interested group of people are confronted with need, their hearts and emotions are touched and their desire is to respond with a “quick fix” to try to bring relief to the situation. For example, if a group of hungry children are encountered, the first response is “to feed them.” This is often an appropriate response, initially, but one soon finds the line of hungry children growing longer and the allocated funds running out.

Relief is a very short—term solution to an immediate crisis and is usually initiated when a crisis occurs that takes the normal way of living and makes it abnormal. One usually thinks of relief following a natural disaster such as an earthquake or flood, when in just a short period of time, the normal way of living is totally disrupted and people do not have the ability to cope without help.

Relief is a good response in the above situations as long as there is a plan to turn it quickly into a development plan that will help people to help themselves and enable them to return to their former mode of living or to a better way.

If relief continues for very long, a dependency occurs and people begin to lose the ability to build on their own capacity and resources. Feeding hungry children without a development plan will quickly deplete resources and the children will be hungry again and will not be any closer to a solution for their hunger.

The river—crossing scene showed the carrying person trying to offer relief. As so often happens in relief, the carrier ran out of energy half way through the attempt to help, and the person was left stranded. Development began to occur when one was trained to help himself and that person multiplied what he had learned and helped another.

**Development** — Development is a process of change where people take responsibility for their own lives. “Community development,” according to Robinson (2001, p 56) “is the process of helping to strengthen a community and its leadership, so that it can resolve the problems that it faces through its own initiative.

**Transformational Development** — Transformational development is defined as helping people to discover who they are in Christ, developing a total dependency on God and allowing the work of the Holy Spirit to change values, beliefs and behaviors. This will ultimately give glory to God and a better life for individuals and communities, physically, spiritually and emotionally (Rowand, 2001, Myers, 2000).

## A Summary of Principles of Relief and Development

### Development

Is long term  
Solves ongoing problems  
Helps people become self—sufficient  
Builds people  
Involves people as participants  
Meets felt needs  
Has a multi—sector approach  
Is insider controlled

### Relief

Is short term  
Solves emergency situations  
Tends to build dependency  
Usually doesn't train people  
People as recipients  
Meets presumed needs  
Addresses single problems  
Is outsider controlled

## Relief and Development in the HIV/AIDS Crisis

The disease of AIDS began to be discovered in the early 80's or perhaps as early as the late 70's. This means that it has been dealing devastating blows to humankind for over twenty years. Normally this would be considered a chronic situation and not one which would call for relief measures. On the other hand, over 16,000 persons are newly infected daily from this crisis, meaning that it is considered to be a “medical emergency.”

Based on this it seems that the HIV/AIDS crisis calls for both relief and development efforts—relief to try to stem the tide of deaths and transmission of the virus by every possible means, and development, meaning to transform lives spiritually and physically so that behavioral change will result in a decrease in transmission. Interventions developed to give assistance to those with AIDS should be initiated by the church and communities and able to be sustained without

dependence of total dependence on outside resources. The above two statements imply a spirit of partnership.

Partnership in the HIV/AIDS crisis is essential to the success of sustainable efforts. This means joining hands with people of like interest, though not necessarily alike, who have the same heart to see transformation of the whole person and whole community occur. At times this partnership will be with multiple sectors of the community: local NGO's, local governments, health systems, other denominational systems, etc. At times it will mean joining hands with outside donors, being cautious that the outside donor does not take control of what the church and community wishes to do.

By putting many hands together it is possible to see the transformation of lives and communities and the tide of this tragic crisis turned in a favorable direction.

May God grant wisdom and divine guidance as the church looks for ways to become integrated in its approach to whole person needs.

## **Questions for Reflection:**

- What types of HIV/AIDS outreach are you familiar with?
- Is the church a main player in the HIV/AIDS outreach in your community? Why or why not?
- Should the church remain focused on evangelism and allow secular organizations to deal with the HIV/AIDS programs and interventions? Why or why not?
- Looking at the outreaches you are familiar with, which would be considered relief and which are development in nature?
- Do you think that development fits within the church context? Why or why not?
- If you could choose between doing relief and development which would you choose? Why?
- What does "whole person" ministry mean to you personally?

# Community Health Evangelism as a Framework for Community HIV/AIDS Outreach

## Scenario for Discussion/Consideration:

(Three church board members having a discussion.)

**First board member** — I just don't understand what the pastor is doing. There are so many souls who have not yet heard about Jesus and he wants us to begin a program for street kids.

**Second board member** — Well the children are hungry and on the streets. It does seem to me like we can or should be doing both — I mean reaching people for Christ and dealing with some of the needs around us.

**Third board member** — No I don't agree with that at all. Let someone else deal with the social needs. We'll get too diluted if we try to do it all. We need to keep our focus on evangelism.

## Questions for Discussion/Reflection:

- What is happening in the scene above?
- What is the underlying problem in this discussion?
- Does this sort of discussion go on in your church?
- What are some possible solutions to resolve this type of disagreement?

## Community Health Evangelism

Community Health Evangelism is a Christ—centered approach to health and development. CHE was pioneered by Stan Rowland in the 1970s while working with Campus Crusade in East Africa. Since that time, under the leadership of Medical Ambassadors International (MAI), CHE has been implemented in over 30 countries. MAI has trained many mission organizations in how to implement their own CHE programs.

## CHE Description

CHE is people taking responsibility for their own physical and spiritual health. The goal is individual changed lives who will affect others, who affect others . . . making possible a community that is changed from the inside out.

The goal of CHE is to equip believers to respond to God's love and to love their neighbors through a Christ—centered health and development ministry. CHE follows the World Missions' fourfold strategy of reaching, planting, training and touching.

**Reaching** — CHE reaches across a broad spectrum of ages and social classes to bring the gospel of Jesus Christ to people in the context of their own homes. CHE helps mobilize and train people not ordinarily involved in evangelistic ministry.

**Planting** — CHE works to strengthen local churches and to help plant new churches through establishing bible studies and cell groups. The approach has been especially effective in helping plant churches in restricted countries. CHE enhances relationships with local leaders and maximizes contact with people of the community.

**Training** — CHE is an extensive training program in skills that promote spiritual, home and family health on a personal as well as community level. The program teaches practical ways to prevent health problems and promote better health. Evangelism and discipleship are taught. The training is designed for capacity building of CHE participants as well as those to whom they will minister.

**Touching** — CHE meets people at their point of need with tangible help. It brings the powerful and compassionate touch of Jesus to hurting lives through the hands of Community Health Evangelists.

## Key Elements of Community Health Evangelism

- **Transformation**

Good health is the result of a personal relationship with Jesus Christ. Relationship with Christ, and not health education, is the dynamic for changed lives that makes good health possible. This transformation is what motivates and empowers people to love and serve their neighbors in the name of Jesus.

- **Training**

Training methods, content, and materials are simple, participatory and easily reproduced so that CHEs can accurately and effectively transfer knowledge to other learners.

Training includes topics in community health and development such as:

Sanitation	Environmental issues
Agriculture	Emotional and social issues
Nutrition	Prevention and care of local diseases
Program Management	Micro—enterprise and income generation

Training in spiritual health and development include:

New life in Christ	Evangelism and discipleship
Personal bible Study	Leading Bible Study & prayer groups

- **Integrated Approach to Health**

Physical, spiritual and social health are seen as integrated rather than separate aspects of health. Jesus is presented as the model for an integrated ministry.

- **Community Ownership**

“Community” may refer to an actual geographical area or to a group of people having certain things in common, such as a church, or a “community” of street children or prostitutes. In CHE, the people of the community are mobilized and equipped to identify and prioritize their own needs as well as locally available resources for meeting those needs. Leadership from within the community is trained to manage and provide direction for the program.

Sustainability is a key concept in CHE programs. Using local resources and implementing small—scale income generating projects is emphasized.

## **Who is involved in a CHE program?**

- **Trainers**

Trainers facilitate community involvement and initiate programs. They train committees and CHEs. A training team usually includes two to four people from different backgrounds and experiences, such as education, health, agriculture, business, or ministry. They are not “experts” in any given field, but serve as liaisons that can contact local resource people when more expertise is needed. Trainers may be volunteers or may be supported by income generating projects or other sources.

Trainers complete three, one—week *Trainer of Trainers* courses over a period of several months. Content includes development philosophy, developing teaching materials, methods and curriculum, as well as program management, evaluation and expansion. Spiritual emphasis is on evangelism, follow—up and discipleship.

- **Committees**

The community or community leaders select 9 — 12 men and women from within the community who will plan, manage and direct the program. These committee members select men and women who will be trained as community health evangelists (CHEs) by the training team. Committee members represent the community to the program, and the program to the community. They supervise the work of the CHEs.

Committee members participate in 15 — 25 hours of training in program planning and management.

- **Community Health Evangelists**

Community health evangelists (CHEs) model and share physical and spiritual teachings with their neighbors in the home setting. They treat basic health problems and facilitate health and/ or development—related projects in the community. CHEs usually volunteer two half—days a week to visit homes.

CHEs complete an average of 150 hours of training over a period of weeks or months. Topics

in spiritual, physical and social health issues are selected from the courses listed on the topics page. Curriculum content is determined by the training team and committee.

1. A Vision Seminar introduces Community Health Evangelism to key people in a given area. People who have a vision for this kind of program are then trained as trainers. The trainers help determine the best location to begin a CHE program.
2. The training team of two to four people come from the outside with different vocational skills. They come to do the following:
  - Raise up a vision in the community for a wholistic ministry
  - Help the community identify their needs
  - Help the community to initiate something
3. The community chooses a committee to represent them in overseeing the work.
4. The training team then trains the committee in their role and helps them decide how they will supervise the program.
5. The committee chooses the CHEs.
6. The training team trains the CHEs in health and spiritual topics and does home visiting with the CHEs during the training period. Topics include agriculture, sanitation, disease prevention and care, as well as evangelism and follow-up.
7. The committee oversees and manages the day—to—day work of the CHEs.
8. CHEs visit 20 to 40 households each month, sharing what they have learned on health and spiritual topics.
9. Community projects are started with the committee mobilizing the people and the CHEs giving technical supervision. As much as possible, funding for the projects should come from the local community. Funds may be solicited from agencies who are interested or working in community health, agriculture, etc., as needed.
10. The training team moves on to another area after a designated time, but the program continues because the community owns it. Major expansion of the CHE program usually takes place by training multiple national community health teams. Model programs can demonstrate how spiritual ministry can be integrated into an existing community health program.

# Applications of Community Health Evangelism

## A Template for Community / Church Outreach

CHE provides a template for wholistic ministry by offering a structure and an approach. CHE can start with any element; i.e. agriculture, literacy, sanitation, clean water, micro—enterprise, etc. CHE is not just medical but can touch all areas of life—physical, spiritual, emotional and social. The greatest needs of the community are addressed first, then other concerns/needs are targeted.

*C* stands for community and *E* for evangelism. They stand on both sides of the different services offered, like bookends that hold everything together. The middle letter could vary like *A* for agriculture, *B* for business, *L* for literacy, *E* for enterprise (CAE, CBE, CLE, etc.) — all different ways to enter a community at the point of need. CHE is a method of offering multiple services to help people live a life that is healthy physically, spiritually and socially.

## Different Models of Community Health Evangelism

- **Community—based Program**

This has been the most commonly used model of CHE, and is especially effective in rural settings or small communities. In this approach, the entire community participates in the selection of the CHE committee, under the guidance of village leaders. Committee members and CHEs chosen by the community may or may not be Christians, and the training is designed to be evangelistic. New converts are incorporated into the CHE's Growth Groups and into local churches (or, if necessary, new churches can be started). Community projects are undertaken under the direction of the committee and with assistance from the CHEs.

- **Church—based Program**

In this model, committee members and CHEs all come from within a church or group of churches working together in a CHE program. This approach may be more effective in urban settings where there is not the same sense of community found in rural areas. The advantage of involving several churches is to help share resources as well as defray the expenses and efforts involved in this kind of outreach. CHE can provide an effective means for churches to demonstrate genuine concern and a practical response to the needs of people in their communities.

- **Family—based Program**

In an area that is antagonistic to Christianity or where there are no Christian churches, the program may be initiated by finding or planting a Christian family who is willing to invite their non—Christian neighbors into their home to be trained in health and spiritual topics. These people will be encouraged to share what they are learning with their neighbors. The Christian family becomes the nucleus for the future development of a CHE Program.

Meetings are usually held in their home on a weekly basis. In addition to the physical topics, pre—evangelism topics may also be taught such as the Moral Value series. Those that are spiritually open are brought into a Bible Study group. This approach is used only if a community—based program would be rejected by the community. A family—based program is designed to function as a pre—cursor to a Community—based CHE program.

CHE is intended to be adapted to the unique needs of the communities in which it is implemented. New applications of CHE are constantly being developed. In Kisumu, Kenya, Agape Children’s Ministry is adapting CHE to minister to the needs of street children. In the Philippines, CHE is being used to reach out to communities of people with leprosy, and has a strong emphasis on micro—enterprise.

## **Available Resources**

For more information about CHE or training opportunities, please contact HealthCare Ministries at (417) 866—6311 / 521 W. Lynn St/ Springfield, MO/ 65802 / [web:healthcareministries.org](http://web:healthcareministries.org)

You may also contact Medical Ambassadors directly to receive the entire curriculum on CD:  
Medical Ambassadors International  
PO Box 576645, Modesto CA 95357—6645, PH: 888.403.0600  
or email [info@med—amb.org](mailto:info@med—amb.org)

## **Community Health Evangelism and HIV/AIDS Outreach**

The advantage of using a CHE model for HIV/AIDS awareness and intervention programs is that basic training in health issues relevant to the community, adult learning styles and personal evangelism have already been taught to the community health evangelism trainees.

Adding HIV/AIDS training in areas of high incidence can easily be done with one of the training manuals available or using the information presented earlier in this course.

The CHEs, as the community health evangelists are called, can become specialists in any of the areas of outreach the church wishes to undertake. In some areas, CHE’s who specialized in HIV are called CHIVEs. The CHE curriculum includes a number of lessons on HIV/AIDS as well as hundreds of other topics.

CHEs can be taught basic counseling skills and counseling for persons with AIDS. They can also learn the basics of pre— and post—test counseling and be used as extensions of the church to partner with testing centers or community support groups.

Community Health Evangelism as a church—based outreach, is taking down the walls of the church and integrating itself into the very fiber of community life. It is a very effective way for a tangible demonstration of the love and compassion of Jesus Christ to enter into community life. It can also mobilize many lay individuals to be involved in HIV/AIDS ministry and provides a step—by—step approach to community care.

## Questions for Reflection:

- What strengths do you see in using a model such as CHE for an AIDS outreach?
- What does using an integrated approach mean to you? Why?
- Why might people be reluctant to use CHE as a model for outreach?
- If you were a pastor, could you see CHE becoming part of your church ministry outreach? Why or why not?
- Can you think of people that you know who would make good CHE's? What are the qualities you are thinking of?
- Which type of CHE application would work best in your community? Why?
- Can you see yourself as a trainer of CHE? Why or why not?
- If you were developing an HIV/AIDS outreach, what are the steps that you would take? Why?

# Unit 3

## Church—based Interventions for HIV/AIDS as Ministry Outreach

### Lesson Six The Church and HIV/AIDS Awareness

#### Lesson Objectives

At the end of the lesson students will be able to:

1. Evaluate various types of HIV/AIDS awareness methodologies and their potential application to the student's own context
2. Analyze adult—learning methods and evaluate their usefulness in HIV/AIDS awareness strategies in the student's local context
3. Evaluate the role of the church in HIV awareness strategies and formulate steps in developing the program
4. Critically interpret the role of the church in effectively reducing the effects of the stigma of HIV/AIDS in the student's local/national context

#### Scenario for Discussion/Consideration:

(Have three or four students sitting in front of a teacher who is reading to them with his or her head in a book, not making any contact and using a monotone.)

**Students** — Looking bored, falling off their chairs due to falling asleep. One raises a hand but the teacher ignores it. Finally the student says “excuse me I have a question.”

**Teacher** — “No questions. Just listen until I am finished with this section.” Teacher then turns his or her back on the students to write on the board (can be an imaginary board). Stays there for some time without turning around.

**Students** — Start to throw things at each other, laughing and talking.

**Teacher** — Without turning around says, “no laughing”.

#### Questions for Discussion/Reflection:

- What is happening in the scene above?
- What are some of the teaching principles that you can not see here?
- Though this is overstated, have you seen this type of teaching?

## **The Church and AIDS Awareness**

AIDS awareness is defined as a clear presentation of the facts about AIDS in a manner appropriate for the learning styles of the audience.

In many non—African countries, people are just beginning to hear about HIV/AIDS, while many people in Africa have been hearing about AIDS for years. Hearing about and understanding the disease and its implications are however, not the same. Even in Africa, there remain many misconceptions about HIV/AIDS and because of the enormity of the problem, some churches and communities struggle with knowing how to impact the situation.

AIDS awareness or imparting the facts about AIDS is important. However, studies are showing that a one—time hearing about something does not always or even often result in behavioral change.

The facts about HIV and AIDS are meant to give people information. The hope is that people will act on that information and change behaviors in their lives that might put themselves or others at risk.

**Unfortunately, one cannot assume that behavioral change will occur by one encounter with the transfer of information.**

Imparting that information in a participatory style (see next section) may enhance the learning process but again may not result in behavioral change.

Information, which is part of a prevention strategy, however, is a starting point. Churches and communities can be instrumental in finding creative ways of continually reinforcing the important and life—saving preventative messages about HIV/AIDS.

In most parts of the world, the crisis requires churches and communities to stay strongly involved in preventative strategies while moving into intervention strategies. Intervention means that many people already have HIV/AIDS and are needing help in coping with the multiple effects that occur when many people are affected (termed epidemic).

## **Participatory Teaching and Learning**

Much of the information below is adapted from Community Health Evangelism, Medical Ambassadors International (Rowland, 2001).

## **Facilitating Learning**

Information about a life—threatening disease that is in most cases preventable is very important information. Knowing about and acting upon this type of information can save a person's life. Therefore the responsibility for imparting information in the most effective way possible is extremely important.

Many persons tend to transfer information by the old standard method of getting up in front of a group of people and “lecturing” or talking about what they know. Often this is done because it is the way in which the teacher was taught.

However, it is fairly well known that people retain much more if they not only hear, but see visual representations of the information. Further, it is known that if people hear, see and “do” something in relationship to the information, there is even greater retention. And lastly, if what people “already” know is drawn out and built upon, even greater learning happens because there is “discovery” on the part of the learner.

The least effective way to encourage learning is by lecturing. The most effective learning is that which involves the active participation of the learner in the learning process and diminishes the role of the teacher or facilitator. This is the reason for the scenarios for discussion found at the beginning of each lesson or new section.

Community Health Evangelism (Rowland, 2001) curriculum uses the following abbreviation to explain the participatory learning process. In this model, the teacher is called a facilitator because the focus is on the learner and their own discovery.

## **LePSAS**

- Learner—centered
- problem posing
- self—discovery
- action oriented
- spirit—guided.

This is a method by which the learners or trainees are actively involved in the learning process.

## **Learner—centered principles:**

### **Start where the learners are at by:**

- Take time for greetings.
- Take time to make sure everyone is comfortable.
- The facilitator tries to call people by name, establishing a relationship or connection.
- All sit in a circle with the facilitator seated—this diminishes the superiority of the teacher concept.
- Learning is written on some type of paper that can be pasted on walls—someone other than the teacher writes.
- Everyone contributes to the discussion.
- The problem is often referred back to the learners for their personal ideas about the question.

## **Problem—posing**

### **Start where the learners are at by:**

- Regarding one single, specific solvable problem for each lesson.
- Posing or presenting that single problem in a simple, clear, stimulating way.
- The single problem is a “starter” for the thinking process, and leads into the discussion. A problem—posing starter, such as a role play or case study or situation which describes one problem is useful because:
  - ⇒ It gets people’s attention
  - ⇒ It stimulates thinking in a group
  - ⇒ It helps to make an image real
  - ⇒ It helps to focus on one problem
  - ⇒ It helps analyze the cause of the problem

## **Self—discovery**

- This builds self worth by being taken seriously by the facilitator and other learners.
- Through dialogue the learner discovers within his/her own thinking, a part of the answer to the problem.
- A good lesson will lead the learner to an “aha” experience which means, “Oh I really understand!”
- Most of the desired knowledge will come from individuals within the group.
- Incorrect answers are modified when they are repeated differently.

## **Action—oriented**

- Good teaching or facilitating is helping people to learn to do something.
- That something is to solve the specific problem which was posed.
- The lesson is completed when learners have made plans for acting on the solution (Who? Where? When and How?).

## **Spirit—guided**

- All teaching should be under the guidance of the Holy Spirit.
- Without the Holy Spirit the teaching can become humanistic.
- The ultimate goal is to teach God’s eternal truths. The Holy Spirit gives enablement for the truth to be accepted and to penetrate into hearts.
- The Holy Spirit guides people to change from the inside out.

To guide the discussion about the “starter,” one can follow a set of questions called the SHOWD questions:

- S** — What do you **see** and hear?
- H** — What is **happening**?
- O** — Does it happen in **our** place?
- W** — **Why** does it happen?
- D** — What will we **do** about it?

The above style of participatory learning and teaching will be used in the training manual which follows. Suggestions will be given for starters but they are only suggestions. Facilitators should feel free to make up their own which may be more relevant than the ones given.

## Types of Awareness Programs

Using the above participatory approach, it is good to find out what the audience knows about HIV/AIDS. This helps the facilitator to adjust the level of the material to the level of the audience and helps to know how much information is needed by the group.

There are many types of HIV/AIDS training manuals, videos and flip charts available—often found at local bookstores or at offices of NGO's that are dealing with AIDS . The internet also has a great deal of information available. **Caution must be used when getting information from the internet as it is not always factual.** Choosing sites that are internationally known such as the World Health Organization or UNAIDS is the best approach when looking for training information on AIDS.

Finding information that has a Christian focus is important as moral and biblical principles can be transmitted while teaching on this subject. A training manual entitled, *AIDS, What you need to know*, has a Christian focus and is available through HealthCare Ministries of the Assemblies of God World Mission (Butrin, 2004).

A comic book entitled *Edward the Elephant* produced by Africa's Children is also available in many languages (Africa's Children, 1995). This has a great appeal with children and young adults. What and how much children are taught about sexuality as it relates to HIV/AIDS will be culturally defined. However, messages about HIV/AIDS prevention need to start with young children and be changed and reinforced as the child grows.

Some type of visual is helpful. Small booklets that can be taken home, reread and shared with other family members and neighbors are also a good idea.

A Zambian woman who is HIV positive related her story to the author. Her husband had gone to a community meeting and received a pamphlet on HIV/AIDS. He didn't tell her any of what he had heard, but left the pamphlet lying the table. She picked it up and began reading. When she read about the symptoms of AIDS she began to wonder if she might have AIDS. She asked her husband if they could both go for an HIV test. He refused so she went by herself and was tested. She was HIV positive. Her husband later went for testing and was also positive. He soon died, but she lived and has dedicated herself to HIV/AIDS awareness (Personal conversation with Zambian woman/Butrin, March 2003).

## Community Health Evangelists as HIV/AIDS Awareness Presenters

In the last lesson, the concept of Community Health Evangelism (CHE) was presented as a model for HIV/AIDS outreach. The principles of adult learning and participatory teaching styles are a part of the CHE training. With training in AIDS awareness, the CHE's, can become CHHIVES (Community Health HIV Evangelists) who can take the AIDS awareness training into the health promotion arena that they are already involved with. In each of the ministry outreaches that will be presented it is possible to consider using CHE as the framework or model on which the programs will be built.

## The Church and Awareness Programs

Before beginning HIV/AIDS awareness training, it is important that persons in the church receive training themselves. Several could be selected to attend a training program and then train others in the church. *It is vitally important that accurate information be taught.* If there are health professionals in the church, they may be an excellent resource and may also be willing to be involved in teaching. All should be thoroughly familiar with the participatory learning style described above.

The church is an excellent setting for AIDS Awareness programs. The main services, Sunday School, women's meetings and bible studies are all excellent arenas for this type of teaching.

Street programs for children, Saturday bible clubs and any type of venue that will bring children and youth to awareness of this critically important information, is also good.

**Public School Programs** — Getting permission to take the training into public schools is also a great avenue of witness for the church. It allows for a larger audience and may impact the lives of many young people and children if it is done well.

Skits, dramas, visuals and some very creative, attention getting strategies need to be employed with presenting this type of material to today's youth. Some programs have utilized young people or adults who are HIV positive, allowing them to tell their story. This is often very effective in making young people think about their choices.

A group called, *Operation Whole*, founded by Vern and Belva Tisdale have had success taking HIV/AIDS drama into public schools in Africa. Governments in a number of countries have opened the doors to all of their public schools for these important presentations. More information about their program can be found on their internet site: [http://www.praisenet.com/harvest/afr\\_tis.html](http://www.praisenet.com/harvest/afr_tis.html)

## Sending a Positive Message and Decreasing Stigma

**A Caring Church** — When the church takes on the task of presenting HIV/AIDS information, it not only may save the lives of church members because of the information they now possess, but it speaks loudly to the surrounding community that this is a caring church. When other churches may be ignoring or judging the AIDS crisis, the church which is actively teaching about this issue is going to gain credibility in the community and with persons with HIV themselves.

**Reducing Stigma and Discrimination** — When the church begins to speak openly about HIV/AIDS and begins awareness programs, it becomes a church with open arms to persons who are HIV positive. This can make a great contribution to helping to decrease the stigma of HIV. It can allow persons to be open about their HIV status and still feel loved and accepted by the church community. No one is more in need of belonging to a group of caring people than persons who are sick and dying or who know that they will be that way one day.

### **Questions for Reflection:**

- Have you heard a lecture one time and then changed your behavior as a result of what you heard? Why or why not?
- What type of teaching/learning do you prefer? Why?
- If you were going to do HIV/AIDS awareness, what type of methods would you use? Why?
- How would you change your methods to teach similar material to young children? Adolescents?
- If you were HIV positive, how do you think you would be viewed in your church? Why?
- Would you describe your church as a “caring church”. Why or why not?
- What are the strengths in your church that would make an HIV/AIDS outreach doable? Why?
- What could you personally do to reduce the stigma of HIV/AIDS in your community?



# Lesson Seven

## The Church and HIV/AIDS Intervention Outreaches

### Lesson Objectives

At the completion of this lesson students will be able to:

1. Critically analyze the church's role in HIV/AIDS interventions which go beyond information and deal with persons affected/infected by HIV/AIDS.
2. Evaluate the ways in which the church might offer "end-of-life" hospice care and formulate a strategy for carrying out a church-based hospice program
3. Determine approaches to counseling services which might be offered pre and post HIV testing or to those dealing with HIV.
4. Construct an appropriate church-based response to orphans and vulnerable children infected or affected by HIV/AIDS
5. Critically assess the appropriateness of a church-based intervention in mother-to-child transmission of HIV/AIDS

### Scenario for Discussion/Consideration:

(Grandmother and teenage girl talking together. Grandmother looks old and sick)

**Grandma** — I know this is so hard for you Teresa. I miss your mother too. It hardly seems like its been two months since she passed away.

**Teresa** — I know Grandma. I know it's hard for you too. I just can't seem to get a hold of myself. And I can't figure out what we should do. Our money is gone. I have to figure out how we will eat next week, but I'm just so sad. I can't seem to get myself up and out to do anything

**Grandma** — I'm going to pray that someone will come by today that can help us know what to do.

### Questions for Discussion/Reflection:

- What is happening in the scene above?
- Can you imagine some people you know who might have this same dilemma happening in their lives?
- What sort of help could the church be to these two?
- What do they really need?

### **Optional Case Studies for Group Dialogue before beginning this lesson:**

Divide the group of students into four groups. Give each group a different case study to discuss which looks at some of the outreaches suggested in this lesson.

#### **For example — Group One — Hospice Care Case Study**

Your church is located near a mining town. Occasionally you have an outreach to the miners and once in a while they will come to your church after such an outreach. The small clinic near the mines is overrun with miners who are desperately sick. The rumor is that they are dying from AIDS. As they are far from their families, they have no one to care for them as they are dying. Your church feels there is something that can be done to help.

#### **Questions:**

- What is the first thing you would do to begin a hospice program for these miners?
- What would be needed for such a program to happen?
- Would any training be necessary and if yes, what should it involve?
- Why would the church want to be involved in this type of ministry?
- What are the main barriers that you think may exist?

## **Awareness and Intervention**

The previously lesson discussed the ways in which the facts of HIV/AIDS might be taught to others. This is usually termed HIV/AIDS awareness — helping people be aware of the facts about HIV and AIDS.

Intervention is a term that can include awareness but more commonly is used when programs and outreaches address issues related to HIV/AIDS other than awareness. Often these are focused at persons who are already dealing with HIV/AIDS in some way, either by being infected or affected by the crisis.

This type of outreach does something to “intervene” in an existing situation as opposed to the awareness programs which try to sensitize people to the problem before it affects them.

In this lesson, the outreaches which will be discussed are considered to be “intervention” strategies and are only suggestions of many varieties of ways that church—based interventions can occur.

## **Church—based Support Groups for Persons or Families Affected by HIV/AIDS**

In many countries, many church families have been affected by the loss of someone from AIDS. In Africa there are churches who are conducting one funeral after another for persons succumbing to AIDS.

It is difficult to know how to help or console families as they face the death of one of their members or who are dealing with the dying process.

Forming support groups which address these issues can be very helpful. As news of the support group spreads, community members who are not part of the church can also be invited to attend. There can be different support groups to address different issues:

- Grief support for family members who have lost a loved one to AIDS
- A support group for families or individuals who are caring for someone dying from AIDS
- A support group for wives whose husbands have left, etc.

**Group Facilitators** — Spiritual and emotional care can be offered during the dialogue times. A facilitator of the group should be given some training in leading a support group, which usually involves asking some leading questions and allowing the group members to share their experiences. Often condolence is offered from other group members who have experienced similar situations. Prayer is often very appreciated during these sessions even by those who do not claim to be believers.

## **Church—based Hospice Care**

### **Scenario for Discussion/Consideration:**

**Person who is ill** — What’s going to happen to me? I can’t believe I’m really going to die. What will happen to my children? I wonder how long I have? Maybe the doctor is wrong—I really don’t feel that sick and certainly not like I’m going to die.

**Friend** — Listen, there is no need to ask all those questions now. Just try to put it out of your mind. Maybe the doctor is wrong, like you said. You should try not to think about it and just go on as you were. Everything will be ok.

### **Questions for Discussion/Reflection:**

- What is happening in the above scene?
- Do you feel that the response of the friend is helpful? Why or why not?
- What might be said to the person who is ill instead?

**Defining Hospice** — The word “hospice” was first used in England to describe a “resting place” for weary travelers. Today the word hospice usually means offering physical, emotional and spiritual care to individuals and their families who are facing a life—threatening illness. Hospice assists family and friends in adjusting to the illness and death.

**Family Units May Be Non—existent or Weakened** — Earlier in the course, it was stated that HIV/AIDS has destroyed many family structures and traditions. The extended family has normally been available to assist those who are dying. AIDS has taken the lives of so many in some areas that the family who remains may be acutely stressed or weakened and cannot manage the total care of the person who is very ill from AIDS. In some cases, there simply are no family members left to care for someone who is dying from AIDS.

Many hospitals are also stretched to the limit of their ability to care for the many dying with AIDS and will no longer allow persons to remain in the hospital when they are near death.

This provides the opportunity for the church to develop a volunteer system for home hospice care or to develop a small facility where people can come to die, surrounded by caring Christians who offer as much physical care as possible and spiritual and emotional support.

**Not an Alternative to Medical Care** — Hospice is not an alternative to institutional medical care. The goal of hospice is to try to help the person who is dying remain as free of pain as possible and as comfortable as is reasonable. Support for physical, spiritual and emotional needs is the goal, but involved medical treatment is not.

Usually hospice or end—of—life care begins when medical treatment can no longer change the course of the illness and death is probable. Though there is always an attempt to retain hope for healing or cure, there is also assistance with the realistic probability that death will occur.

Though some medical treatment may continue to be given at another location, hospice will provide comfort measures primarily. Due to this, persons offering this type of supportive care do not need to be health professionals or particularly skilled in any one area,

The financial resources of those who are dying are often greatly depleted, and church projects which help support those in need are often of great help.

Taking on a hospice program requires a great deal of commitment on the part of the church, especially in relation to prolonged volunteerism. Also, some basic training in caring for someone with AIDS is necessary. One needs to know how to meet physical needs and also to offer emotional and spiritual support.

A team approach is most ideal—a health professional, volunteer aid workers, a counselor and a pastor. But even if only laypersons are available, the assistance and presence of a caring person would be greatly appreciated by the person who is dying.

Training and program setting cannot be covered in this course. A Manual entitled, *A Manual for Hospice Care* is available through HealthCare Ministries (Butrin, Morgan, Davis, & Pandolfo, 2002).

## **Church—based Care of Orphans and Vulnerable Children**

### **Scenario for Discussion/Consideration:**

**Husband with AIDS** — I don't want to discuss this. Don't ask me again. I'm not going to die yet and I don't want to think about what I want to do with things. We'll have plenty of time for that.

**Wife of person with AIDS** — But if we don't have something in writing, I'll lose everything when you die. Your brothers will take the property and the house and who knows what will happen to the children. All you have to do is write your wishes on a piece of paper and then it will be okay.

Husband — I don't want to talk about this anymore. I'll do it when I'm ready and not before.

### **Questions for Discussion/Reflection:**

- What is happening in the scene above?
- What is the husband really saying?
- Why is it important that these things be taken care of?
- Does this sort of thing happen in your area?

Caring for the children who are orphaned or made vulnerable by HIV/AIDS is an enormous task because there are so many facets to this type of ministry. It is a long—term undertaking that requires a great deal of commitment and financial resources.

It is an overwhelming problem in Africa where approximately 11 million children have been orphaned by AIDS. However, as HIV/AIDS becomes epidemic in other places, it is becoming a greater problem.

In the past, the first thing that was thought of when children were orphaned for any reason was to gather them together in orphanages and try to care for many under one roof.

In recent years, this practice has come under criticism as being an expensive way to deal with the problem and also one which may not be in the best interest of the children. Institutional care cannot give the child as much attention as they need and does not teach them about family values and traditions of their culture. They become foreigners in their own country.

The subject of caring for orphans and vulnerable children is too large to be completely discussed in this course. But several ideas of church involvement will be listed. It is an excellent topic for church discussion and guidance by the Holy Spirit may result in commitments of the church to undertake this vital ministry.

As was mentioned earlier in the course, the first thing to be done after prayer and determining the will of God and the church is to do an assessment. It may be that the vulnerable children are being cared for by other community programs and that this is not the greatest need. However, if it is found that many children are being made vulnerable or orphaned by AIDS, and there seems to be no one taking on the task, then the church is well placed to begin an outreach.

The following are some of the ways that churches have been responding to the crisis of the orphaned children:

**Reunification programs** — Many children who are on the streets are not actually orphaned but for many reasons have chosen to leave home. Others have been separated from their families due to wars or natural disasters. And others have lost their parents to AIDS but do not know or are distant from their family members. Reunification tries to find the families of the children who seem to be displaced. If the family is there but the child has left, an evaluation of the possibility of reconciliation is done. Other programs try to find extended family members and help to make arrangements for the children to get placed into these families. This is a difficult undertaking

and though important requires diligence and many hours of concentrated effort to even locate separated families.

**Foster care** — Foster care involves finding good Christian families who are willing to add a couple of children to their family. A program of screening of perspective families and the following of government regulations needs to be considered before this is undertaken. Churches may be involved in setting up such a program or helping to provide assistance funding to families who have taken in orphaned children.

**Support for families that are without resources** — Sometimes a spouse remains in the home, but has no resources with which to care for her children. The remaining spouse may also be sick and dying from AIDS. The church can be a wonderful support and witness to this group by finding out who is struggling and taking special offerings of funds or food to distribute to the most needy. Sometimes in rural areas, assistance with farming or life skills is given. If the person surviving in the family is well enough to work, it is good to provide work opportunities so that a dependency is not formed and the recipients do not feel like “charity cases.”

**Support for child—headed households** — When both parents die, there are often older and younger children who make a decision to try to stay together. It is so important that parents who are dying make written statements that direct their houses, lands and goods to be left to their children. Otherwise, as stated in the opening scenario, the children can be left with nothing at all to carry on.

Those that do have a home often need assistance, however. Some churches and neighborhoods have developed a volunteer plan of visitation whereby someone in the community will stop in every other day or so, make sure the children are getting enough to eat, help them do housework or show them how to work in the garden. They are especially attentive to the emotional needs of the children. Often churches can direct funds or food to this type of arrangement to make sure the children have money to continue their education. Though this may not seem ideal, it does give the children the sense of continuing to belong to a family unit and at times is better for the children than an extended family who really does not want them.

**Group homes** — A method of taking in orphan or vulnerable children which works well for a church—based outreach is that of the establishment of group homes.

The church usually assists in choosing a Christian couple who may or may not have children of their own, to be the “house parents” to about eight orphaned or vulnerable children.

The church or outside donors may provide a large house for the group home. Ideally, the group house should be one which is similar to what most families live in and not something with a “foreign” look. The aim is to make the children feel like they are part of a “normal” family and not stigmatized by being in something very different from the rest of the surrounding community. If outdoor kitchens or bathrooms are what most people have in that particular community, then that is what the group home should have.

Usually the church must make some type of commitment to help with food for the children. School fees and life skills training are often other resources needed to keep the group home functional. Some larger churches in Zambia, for example have a group home for boys and one for girls, averaging about eight children per home. A bakery is part of the micro—enterprise which helps to support the homes and the older children learn the skill of bread making with the hope that they will have a way to support themselves when they leave the home.

Christian values can be instilled in the children when they come into the home and this becomes a way of bringing up children who love the Lord and a way of keeping the children off the streets.

## **Church—based HIV Testing and Counseling Outreach**

### **Scenario for Discussion/Consideration:**

Two young men talking together.

**Sam** — Man, I've been feeling bad lately. I'm so tired and I seem to have diarrhea all the time. I wonder what's wrong with me. Sometimes I worry that I might have AIDS.

**Joseph** — AIDS! — Man, there is no way you have AIDS. You look like the picture of health. You always use condoms don't you?

**Sam** — Well most of the time, but not always. I don't know. I just wonder. Ah well, like you said, I look healthy. And besides, if I have it I'd rather not know. Might as well enjoy life while I can.

A large percentage of persons who are HIV positive do not know that they are. Some, as in the above scene, may suspect that they are, but do not want to know. Others, though they may wish to know, fear discrimination and rejection and stigmatization if they find out their status.

However, the studies have been noting that once people know their status, they are more likely to change their behavior. If individuals are tested and find out they are negative, they are found to be more likely to avoid high—risk behaviors. If individuals learn they are positive, they too may act more responsibly and be concerned about not infecting others.

For these reasons, HIV testing is seen to be a prevention strategy and is a very important intervention. Testing, however, rarely stands alone. Because the results of the test have the potential to be devastating to individuals who are positive, counseling before the test to help persons prepare for the results is almost always done and counseling immediately after the test is also very important. This is called Voluntary Testing and Counseling (VCT) by most organizations. More will be said about counseling in a later section.

One can immediately see how important the role of the church and/or Christian counselors is in the pre— and post—test counseling of persons being tested for HIV/AIDS. It is difficult to present hope and help without including a spiritual component and who better to do this type of counseling and care than those who know hope in Christ.

According to the World Council of Churches, over 80% of the world's population identifies itself with a religious community (World Council of Churches, 2001). The church is usually respected by the communities it serves, it brings people together regularly and it exists at every level—rural and city, local and national. The church is present at the grass roots of the places being most affected by the HIV/AIDS crisis, therefore has a unique capacity to address the problems related to the epidemic.

Some churches have decided to take that pro—activity one step further and actually begin VCT as part of their church outreach. A large urban church in Kenya has restored a van, recruited and/or trained counselors from the church, recruited a physician and offers neighborhood testing and counseling as a Saturday outreach ministry.

Other churches have partnered with local clinics who have agreed to do the actual testing while the church trains and offers voluntary counselors to deal with the pre— and post—test counseling with a spiritual emphasis.

Before the church or any group decides to begin a VCT program, it is important to do a needs assessment to determine if there is a true need for the type of outreach being considered and what is presently being done. The following is the type of information that needs to be sought but is not a complete or formal assessment guide. A committee should be formed, which has as its task, answering questions such as those posed below.

### **Information to Seek in a Needs Assessment for VCT**

- How prevalent is HIV/AIDS in the area served by the church?
- What VCT programs already exist? Are they Christian organizations and are spiritual issues being adequately addressed?
- Is there a reason why a church—based VCT would be better than what presently exists?
- Are there personnel within the church who could be involved such as counselors, medical personnel, etc?
- Is training for counseling and testing available locally and who would be trained?
- Is funding available through local NGO's, foreign NGO's or the government for VCT and what costs are covered by these funds?
- Are there local clinics that could form a partnership with the church to allow the counselors to be trained and sent by the church?

(This is not a complete assessment form but gives an idea of the type of information which would be useful before beginning a VCT project.)

Once the assessment has been completed and the church leadership feels that there is a valid need for the church to become involved in VCT, agreement of the church as a whole should be sought. A proposed budget and the need for volunteers should accompany the information given to the church about the VCT.

***If VCT is a part of the church, it should naturally follow that the church has decided that it will be a safe refuge for those who are HIV positive.***

Usually counselors who will be working full—time will need to be paid and that may be the largest expense of the program. This is often why churches who decide to take on this type of project do it part—time with volunteer counselors who have been trained or who are already trained.

It is beyond the scope of this course to provide the technical infrastructure for setting up all aspects of the program. It is strongly recommended that delegates from the church be sent to study an existing program, meet with local government officials and other non—government organizations to find out about regulations and funding. A reference manual for VCT is The HIV Testing and Counseling Manual (Butrin, 2003).

Though it entails many details and work to put the program and structure together, the outcomes of such a ministry can be great. They may include (Faith Based Organizations, 2001):

- Helping to de—stigmatize HIV/AIDS in the church and community
- Promoting behavioral change consistent with the teaching of the Word of God
- Being a hand of grace and help to those hearing of a terminal illness diagnosis
- Providing spiritual direction for those facing eternity without Christ
- Demonstrating the love of Christ through providing a vital service for the community

Summarizing the steps to beginning a church—based VCT program:

- Someone with a vision
- A burden and direction of the Holy Spirit
- Assessing the need
- Assessing resources available through NGO's, local governments, etc.
- Congregational acceptance including willingness to incorporate HIV positive persons into the church
- Determining the budget
- Determining how the budget will be funded
- Who will manage the program?
- How will it be sustained?
- Will it be a full—time program of the church, a part—time outreach, or a partnership?
- Who will be trained and who will do the training?
- What are the objectives of the outreach?
- How will the objectives be measured to assure that the program is being effective?

#### Church—based Prevention of Mother—to—Child Transmission (MTCT) Programs

Pregnant women who are HIV positive have about a 30% chance of passing the HIV to their baby either while in the womb, during the birth process, or while breast— feeding.

In the section on Facts About AIDS, it was stated that there are two drugs most commonly used that can be given to pregnant mothers near or during delivery that will reduce the risk of transmission

of the virus from mother to baby by 50%. Most all of the distribution programs for these drugs require that the mother be tested before receiving them. This is to ascertain if she is HIV positive and really needs the drug. Many women find out for the first time that they are positive.

Pre— and post—test counseling are also a part of the MTCT program. Though the distribution of the medications is usually done at prenatal clinics or hospitals, some churches have partnered with these health centers to provide the counseling and spiritual care in the pre and post counseling sessions.

The ramifications of this testing and a positive result are enormous for so many women in so many parts of the world. How very vital it is for those filled with the love and compassion of Jesus to be at the side of these women at such a desperate time.

MTCT is yet another way in which the church can reach out a hand of care to someone in crisis.

## **Questions for Reflection:**

- How valuable do you think the church really is making a difference in the HIV/AIDS crisis? Why do you feel the way you do?
- If someone wanted to tell you some facts about AIDS, what method of instruction would appeal to you most? Why?
- If you were a pastor or are a pastor, what would you think you should do about the HIV/AIDS crisis? Why?
- Would it be better to let the community and secular programs deal with most of the programs listed in this lesson? Why or why not?
- Which of the programs listed in the lesson seem most feasible to you as a church—based outreach? Why?
- How likely is it that church members will want to participate? If not, what are ways to inspire and engage the church?

# **Lesson Eight**

## **The Church Affecting Change in Groups at High Risk for HIV/AIDS**

### **Lesson Objectives**

At the completion of this lesson students will be able to:

1. Identify the groups considered to be at high—risk for HIV/AIDS in the student's own local context
2. Critically evaluate ways in which the church might minister to groups at high risk for HIV/AIDS infection
3. Assess the appropriateness of the church's involvement with ministry to sex workers
4. Identify "best practice" church—based outreach which have been successful in various locations and in the student's local context

### **Scenario for Discussion/Consideration:**

Three people doing street witnessing — passing a prostitute who beckons them to come and check her out.

**First Witness** — Can you believe that hussy? What nerve?

**Second** — Let's hurry up and get out of here. I'm afraid she'll approach us.

**Third** — She looks so haggard and sad. Maybe we should try to witness to her.

**First** — Are you kidding? You can't talk to people like that. She would never listen to us.

### **Questions for Discussion/Reflection:**

- What is happening in the scene above?
- What attitudes are being expressed?
- Is it possible to witness to a sex worker on the street?
- What response might be given?
- Are sexual workers common in your area?

# Identifying Groups Which are at High Risk for Contracting and Transmitting HIV/AIDS

Different countries will have different classifications of high—risk groups. But in general the following are usually considered to be high risk for contracting and transmitting HIV:

- Adolescents
- Street children
- Bar maids
- Sex workers
- Truck drivers/mine workers
- A spouse with an unfaithful partner

The purpose of this lesson is to determine why these groups are high risk and to examine the possibility of a church—based outreach to affect the lives of those at high risk both for the present and for eternity.

## Adolescents

Statistics in most every country where AIDS is epidemic report that the greatest number of cases are found in the 15 to 24 year—old age group. This is true in the Caribbean as well.

Adolescents are at high risk for several reasons. Adolescents are under considerable pressure from their peers and perhaps their culture to begin early exploration into sexual activity. In some cultures, by the time a young man has reached the age of 14 or 15, he is expected to engage in sexual relations to “become a man.” Not having done so would expose the teen to ridicule and even disappointment from his father, brothers and uncles.

Adolescents are also given to a high sexual drive. This causes them to engage in sex with multiple persons as frequently as possible. Young women are not exempt from these exacerbated feelings and often experience similar peer pressure as the boys. At times, young girls are feeling a need for love and protection and, when receiving such promises from young men, give in to the pressure of sex to “prove they love or are loved.”

Adolescents often have an attitude of immortality, fearing little and feeling that “nothing can happen to them.” For this reason, they may be reluctant to use condoms because they really don’t think they are vulnerable to getting sick.

## How can the church effectively minister to adolescents?

### Questions for Discussion/Reflection:

- What is the church youth group doing to instruct young people about HIV/AIDS?
- How does the church deal with the attitude of immortality?
- Does just telling young people they should not engage in premarital sex work?
- What are some creative ways that young people can assist other young people in committing to purity and “saying no” until marriage?

- What do you think of requiring an HIV test when a couple is considering marriage?

The message of the Good News of Jesus Christ and a personal relationship with Him should be a driving force in helping young people to stay pure and refrain from sexual activity. Unfortunately, though many young people accept Christ, the temptations and struggles to give in to immorality are strong and many young Christian people fail to resist the temptation.

There are also multitudes of “un—churched” young people who have no moral code to guide their behavior.

Youth groups in churches must deal with the consequences of immoral behavior and should be inundating the young people with facts about AIDS. However, young people do not respond well to being lectured and often do not take ownership of the issues if they are not directly involved in the learning process.

Though embarrassing for some, it is essential these days to speak frankly and openly to young people about sexual issues.

Some creative ideas may include:

- Involving the young people in role plays and skits similar to those in this course
- Having the youth design visuals and programs to reach out to non—church people with morality and anti—HIV messages
- Inviting non—church youth to an anti—AIDS fair which will present drama and song concerning the AIDS epidemic
- Having small dialogue groups where young people can feel safe to discuss their struggles with a mature and understanding adult
- Having the young people make up songs and posters about abstinence and fidelity and repeat these themes every time they come together
- Having the young people prepare teaching sessions for the adults

## **Street Children**

Children are on the streets for many reasons. Usually conditions in their homes were such that they could not stay. Some have lost parents to AIDS or other illness and did not have or could not tolerate the relatives who may have taken them in. Others were abused, neglected or the family simply could not support them.

For whatever reason, children that go to the streets to live their lives usually become involved in crime, sex, drugs and violence (Richter, 1997). It is almost inevitable, given their lifestyle, that they will contract HIV/AIDS and pass it on.

Girl children are at particular risk for HIV infection because they have little control over what happens to them. Rape, prostitution and survival—sex are the norm. In a study conducted among street children in South Africa, Richter and Swart—Kruger found that most respondents agreed that selling sex to both men and women is the best way to get money on the streets. In addition, the street children reported that their clients usually insisted upon unprotected penetrating oral, anal or vaginal sex (Richter, L. & Swart—Kruger, J. 1995).

# How Can the Church Effectively Minister to Street Children?

## Questions for Discussion/Reflection:

- What can the church do to reach out to street children?
- What kind of resources are required to undertake this type of ministry?
- What kind of training or preparation would be needed to deal with this population?
- What would be the anticipated problems?
- What outcomes would be hoped for?

Street kids are desperately needy children that are not shown love or compassion at any level. Usually they are seen as repulsive and despicable and usually tend to be shunned by most people (Kilbourn, 2002). Most, however, did not choose the lifestyle they are in, but were forced to the streets by the negative circumstances of their lives. For some, it is the only mode of survival that they know.

It may be somewhat overwhelming for the church to consider a ministry to children on the streets. However, many around the world have begun to reach out to these needy children and have found that, though not easy, the children are hungry for more than just food. Rather they are starved for love, for touch, for acceptance and for someone to care (Kilbourn, 2002).

Phyllis Kilbourn, in her excellent book, *Street Children*, says that though ministry to street children is enormous and complicated, God can plant a vision in the hearts of the church members for how it might best be accomplished. She says that it takes a great deal of planning, perseverance and a very large commitment of the entire church to implement and sustain such an outreach (Kilbourn, 1997). Types of ministries that have been tried are many, but below are some ideas:

(Gaining trust and forming relationships with the children is the first step to any outreach.)

- Sidewalk Sunday School
- Puppet Shows — especially talking about AIDS
- Feeding stations
- Drop—in centers — A place where children can come to wash, to get some food, to talk with someone, but usually not to stay overnight unless they feel they are in danger
- Foster Care — Providing Christian homes that are willing to take in one or several children and provide for their needs
- Group Homes — A small, culturally relevant home that can house up to eight children and make the atmosphere as much like a family as possible. Often the church can provide the house, or offerings for food and school fees, and/or provide life—skills training
- Micro—enterprise to support school fees for orphans and/or provide for medical needs

## Bar Maids and Sex Workers

Bar maids have been cited as being at high risk for HIV/AIDS because of their tendency to have sex with their clientele after work. Though not considered to technically be prostitution, it is a very similar way of making money and receiving and transmitting HIV.

Sex workers practice illegally in some countries, but in many countries, it is either legal or the prohibitions against it are not enforced. Sex workers are thought to be one of the highest risk populations for HIV/AIDS because of the multiple sex partners.

Though many street sex workers are well informed about protecting themselves against HIV with condoms, many were already positive before they began using condoms and some, being so desperate for money, will have sex without condoms if their customers insist. For example, a Pan American Health Organization Fact Sheet says, “Forty—six percent of sex workers are HIV positive in Georgetown, Guyana — one third have said that they had never used a condom with a client” (PAHO/WHO/UNAIDS 2001),

One may tend to sit in judgment of women who would sell their bodies and put their lives at risk for money. However, women on the streets often feel that there are no other options available to them. They may be trying to support children that they have and may have had husbands who left them to fend for themselves and their families. Girl children, have at times been sold into prostitution by their parents and through, no fault of their own have been imprisoned and forced into the sex trade.

Rather than judgment, it would seem that an emotion of sorrow for the circumstances that have taken women to this level of behavior and compassion for their plight would be the appropriate Jesus—like response. Though never condoning sin, Jesus reached out to those that were lost.

## **How Can the Church Minister to Bar Maids and Sex Workers?**

### **Questions for Discussion/Reflection:**

- Is it appropriate for the church to have a ministry to bar maids and sex workers? If no, why not?
- What kinds of outreach might be done by the church?
- What would be the goal?
- How could HIV/AIDS education factor into the outreach?
- What resources would be required for such an outreach?

In every situation of ministry one can ask the question, “What would Jesus do?” The bible is a wonderful guide to the church and believers when challenging ministry situations are being considered. Recall the role play where the people who were doing street witnessing felt that there would be no way to approach the street prostitute. Then recall the story told in John 8:3—11 of the woman who was caught in adultery. The Pharisees and teachers of the law were ready to stone the woman to death for her sin. His reply to them was, “If any of you is without sin, let him be the first to throw a stone at her.” (vs. 7)

There is not a great deal written about church—based ministry to prostitutes. Teen Challenge, a drug rehabilitation program, works with prostitutes in India. The organization attempts to first of all form friend relationships with the women. Some of the programs provide daycare or more often nightcare for their children while they work. Some have opened schools in the red light areas for

the children to attend and often teach the children bible stories. Bible studies, witnessing points and counseling help have also been offered. One program has provided a free clinic for the women and there they meet people who can offer spiritual care as well as medical care. There are several programs that offer to “rescue” the women from the streets and take them to safe shelters far away from the place where they have been working. Unfortunately, though the intent of the shelters is to provide rehabilitation and life skills for the women to begin a new life, many of them are coming out HIV positive and are assisted to die rather than to live.

As in any of these ministries, it takes a commitment of the church and many volunteers to work among this desperate group. However, they, like anyone who does not have a relationship with the Lord, are worthy of the love, compassion and care of the believers and the church.

## **Truck Drivers**

Many studies which have been documenting the progress of the HIV/AIDS crisis have attributed the rapid spread of the virus, geographically, to truck drivers.

Since road travel for truckers takes them away from home for long periods of time, there are favorite “truck stops” along common routes that come equipped with sex workers as well as showers and food. Often the truckers are carrying large quantities of money to pay for gasoline or from payments for the goods they’ve carried and they become envied prey for the sex workers (Survey of truck drivers, 2004).

They may pick up the HIV virus at one stop and transmit it along the route they are traveling which may take them from one end of the country to another or even to another country—thus the geographic spread.

## **What can the church do to effectively minister to truck drivers and help to prevent the spread of HIV?**

### **Questions for Discussion/Reflection:**

- Given the travel and infrequent visits home, what might the church do to reach out to truck drivers?
- Are you aware of any church—based or government programs that are specifically designed for truckers?
- How many truckers in your area might have a radio or cassette player in their truck?

In the United States there are several organizations that have been started to offer spiritual care to truck drivers. Usually the truckers are met at truck stops, talked with, witnessed to and invited to local churches, etc. One such ministry, called the “Truck Drivers’ Chapel Ministry,” claims to have won over 550 drivers to Christ through personal witnessing at truck stops and inviting drivers to come to church (Harris, date unknown).

Possible interventions would be:

- A radio broadcast specifically designed for truckers with gospel witness and HIV/AIDS education
- Posters and tracts at popular truck stops
- Volunteer church members to meet with truckers at truck stops, to witness and invite them to church
- Special meals that are prepared to which truckers can be invited where a witness and program on AIDS could be presented

## **A Spouse with an Unfaithful Partner**

So often spouses with a chronically unfaithful mate are not considered as part of high—risk groups. Most often, the unfaithfulness is among the men, rather than the wives. This is due to logistics of the wife being at home while the husband is out and in contact with other women and because in some cultures there is an unspoken acceptance of men having mistresses or visiting brothels. When men are dominant, where machismo is acceptable and where women are considered inferior and with few if any rights, women can be put at high risk to be infected by their unfaithful husbands.

In many countries, the stigma of AIDS is so strong that a woman fears to be tested, even when she suspects her husband's unfaithfulness, because she knows that she will be banished from the home or her husband will desert her.

Many women discover they are HIV positive only when they become pregnant and are tested prior to giving birth. Even then, knowing that they might protect their unborn child from HIV transmission, many women are reluctant to be tested.

As part of the ABC method of prevention mentioned earlier in the course, the B stood for BE FAITHFUL in marriage.

## **The Church's Response to Infidelity Resulting in HIV Transmission**

### **Questions for Discussion/Reflection:**

- What can the church do to respond to the problem of marital infidelity?
- Do you think that teaching about HIV/AIDS will have any impact on reducing the tendency toward infidelity?
- Do you believe that changed hearts equal changed behavior?

Long before AIDS was ever a consideration, infidelity in marriage has been wreaking havoc on men and women's lives. Discovering that a mate has been unfaithful often causes divorce, bitterness and a multitude of problems for the families involved.

The gospel with its message of moral living and fleeing from temptation and sin, brings a great difference to this challenge. At the forefront of all activities directed toward high risks groups, is the strong effort to bring people into a relationship with Jesus Christ. Most often, once the heart is changed, and there is a deep and strong commitment to God, the likelihood of high—risk behavior is much less.

Any ministry which points people in the direction of Christ is a valid undertaking. However one can also see how the church can become a “safe harbor” where fear of HIV disclosure is not present. As the church relates to and reaches out in the crisis of AIDS, people will begin to realize that if the church can accept someone with AIDS, then any one can. The church should be and can be a leading agent in reducing the stigma associated with AIDS.

When stigma is reduced, women may feel more confident in being tested if they suspect infidelity. They may also feel, as they become part of the church family, that they are not alone in the situation and can better deal with the infidelity and possible HIV status resulting from it.

# Unit 4

## Counseling and HIV/AIDS

### Lesson Nine Principles of Counseling

#### Lesson Objectives

At the completion of this lesson the students will be able to:

1. Construct an appropriate definition of counseling and identify the most common types of counseling available in the student's own context
2. Outline important qualities of a counselor and critically assess if these qualities would be important in the student's own culture
3. Evaluate the communications styles which would be most effective in the students local context
4. Analyze the impact of individual culture on a counseling encounter and identify strategies to overcome cultural barriers which may exist
5. Determine if "universals" exist in counseling and evaluate the role of the Holy Spirit as a universal communicator.

#### Scenario for Discussion/Consideration:

Another person walks in to take a chair in front of the counselor who is yawning, looking tired, wiping eyes.

**Counselor** — "Wow, it's been a very long day. I'm so tired. So how are you? Sorry about the long wait—we've just had so many people to counsel with today. Seems like the line never ends. Problems, problems, problems—everybody has a problem. So, how are you?"

#### Questions for Discussion/Reflection:

- What is happening in the scene above?
- How would you feel if you were the client?
- What are the implications of the words of the counselor?

## Definition of Counseling

There are many definitions that could be given about counseling. Simply stated, however, counseling is a face—to—face relationship with the goal of helping people to gain new skills which will enable them to adjust to and cope with life situations, particularly those which are adverse.

Learning about an HIV positive diagnosis of oneself or a family member is indeed an adverse situation. HIV voluntary testing provides an excellent opportunity for a skilled counselor to have a face—to—face encounter with someone facing the enormity of impending disease and death. It also gives opportunity for spiritual values to be reviewed.

The following two chapters will deal more in—depth with counseling that is specific for the AIDS crisis. This chapter, however, will also review basic counseling or helping skills which can be used for any type of adverse situation.

## Attributes of a Counselor or Helper

The counselor's values and attitudes play a critical role in the helping process. Counselors should enter the counseling relationship with a sincere *respect* for the persons they will counsel, with an *open* and *genuine* and *non—judgmental* attitude and the goal of helping clients to take responsibility for their own lives (van Dyk, 2002, p. 211).

**Respect** is an attitude which demonstrates the belief that every person is a worthy being who is competent to decide what he or she really wants from life. Without an attitude of respect, the counselor cannot facilitate growth because it will not be possible to create an atmosphere of acceptance and freedom in which the client can reveal his or her deepest, darkest or most painful feelings without fear of rejection (Du Toit, Grobler & Schenck, 1998, p. 77).

- Respect involves accepting the client by showing unconditional positive regard. The counselor accepts the client just as he or she is, regardless of the client's values or behaviors.
- Respect allows that each person is unique and deserves to have counseling sessions individualized to meet his or her specific needs.
- Respect means that the counselor will refrain from judgment and blame. This is particularly important when counseling someone with HIV.
- Respect acknowledges and honors individual diversity in culture, ethnicity, spirituality, sexual orientation and socioeconomic status (Du Toit et al, 1998, Egan, 1998, Long, 1996).

**Genuineness** is a way in which counselors relate to their clients. The following are ways in which genuineness is played out in the counseling relationship: (Egan, 1998; Gladding, 1996)

- Be real and sincere.
- Be honest with yourself and the client.
- Don't be patronizing or condescending.
- Keep the client's agenda in focus.
- Don't be defensive.
- Be open and accepting.

**Empowerment** is a powerful term which means that the counselor helps clients to take responsibility for themselves and to identify, develop and use resources that will help them to be more effective in dealing with the life situations which they face.

The following attitudes and behaviors of the counselor assist in empowering clients (Egan, 1998, pp. 52—53):

- Believe in the client's ability to grow and move beyond their present state while realizing that the client has a right to set their own goals and pursue them from his or her own point of reference.
- Believe in the client's ability to change if he or she desires to do so. The counselor should hold a basic belief that the client has resources to participate in the counseling process and to manage his or her life more effectively.
- Hold back from attempting to “rescue” the client by taking responsibility for the client's feelings, choices or actions. Rescuing often reflects the rescuer's need.
- Share the helping process with the client.
- Help clients become better problem solvers in their daily lives.

## **Confidentiality**

Guarding the confidence of what is told to you by the client is absolutely essential in the counseling relationship. Guarding the confidence placed in you by the client is another way of showing respect. No information shared by the client, including HIV status, may be shared with anyone without the consent of the client.

More will be discussed about confidentiality as it relates to HIV status and disclosure in subsequent chapters.

Any written notes which concern the client's condition or information disclosed by the client should be carefully protected and kept in a locked area where it cannot be accessed by others.

## **Communication Skills for Counseling (Helping)**

In addition to the attributes listed above which characterize a healthy counseling relationship, there are some basic communication skills which are essential to help another person talk out the issues they are dealing with.

**Listening skills** — Listening is hard work and takes focus and determination. Often when dealing with those who are struggling with life issues, the caregiver will not have answers.

- In some cultures, listening involves making eye contact to show attention. In others, this would not be appropriate, especially if genders differ.
- Make sure you are close enough so you can reach out and touch while listening, again, if that is a culturally appropriate thing to do. Even if you don't touch, be close so the person doesn't have to strain to talk.

- Don't interrupt unless you don't understand and need clarification. A useful phrase is, "I thought I heard you say," or "let me see if I understand what you are saying."
- Remain neutral while listening. Don't jump in with your point of view.
- Don't try to finish sentences for people. Sometimes it may take awhile to express what they need to say.
- Try to listen with the body, leaning in, nodding, letting the person know that what they have to say is important.
- Don't feel that you need to have answers to the questions that may be posed. Saying you don't know is o.k.
- Try to really hear what is being said. Reflect on what is being said and share your reflections when appropriate so that the person feels "listened to."

## **Attending or Presence**

Attending refers to being fully present and focused on the individual with whom you are speaking. It means concentrating on what is being said without allowing one's mind to wander. It can mean sitting forward or leaning toward the person. Assuming an open posture, i.e. not crossing arms but letting the person feel that you are allowing what they say and who they are to be accepted by you, assuming this is culturally appropriate behavior.

## **Reflecting Back or Restating**

Some people have difficulty in expressing their feelings clearly or are not sure what they are trying to say. Restating with phrases such as:

- I think I hear you saying...
- Repeating or rephrasing what has just been said...
- Let me see if I understand what you are saying...

## **Touch**

Touch can be a powerful communication tool, but is not always appropriate. Usually it would not be used when counseling with someone of the opposite sex. It may also not be culturally appropriate to touch even when of the same gender. However, there are times when a gentle pat or touch on the hand or arm, or a hug as the person leaves, communicates caring and acceptance and may be very meaningful to someone who lacks self esteem or is feeling low.

## **Divine Guidance**

There is a difference between Christian and non—Christian counseling and that is that Christ is present in the encounter. A Christian counselor relies greatly on the guiding of the Holy Spirit to help to bring understanding and insight into what the counselee is feeling and thinking. As one relies on the Holy Spirit, there is often insight beyond human understanding and words of comfort and care that go beyond what can humanly be communicated.

## Unhelpful Communication Styles

- It isn't helpful to say, "I understand exactly what you are going through," even if you feel that you do. Every person's experience is uniquely theirs and no one else can know exactly how another feels.
- Badgering, expressing opinions, or putting down what has been said is never helpful.

## Cross—Cultural Issues in a Helping Relationship

Whenever a counseling relationship involves two people from different cultures, ethnicity, or background, there is need for sensitivity to those differences. Bias and prejudice can also influence a helping relationship particularly in the areas of religion, economic status, sexual orientation or lifestyle. It is important for the helper to be aware of any bias or prejudice about these differences. If they exist, it is best to identify them and then attempt to set them aside. If the bias or prejudice is so strong that the helper cannot be non—judgmental, it may be best for someone else to deal with the needs of that person (Granich & Mermin, 2003, pp. 102—104).

Though persons may be universally "affected" by negative circumstances in their lives, the ways in which they process the event and deal with and express their feelings may differ from that of the counselor. The key to effective cross—cultural counseling begins with awareness of those potential differences. The best way to attempt to understand those differences is by asking questions, a key to a good helping approach. Questions like:

- Tell me how you are feeling about...
- What does it feel like to you...
- What does this event mean to you...
- Why do you think this happened or is happening....

Some important considerations in a cross—cultural counseling situation are:

- Some cultures do not place value on "I" thinking or exploring personal feelings. This stems from the "group" or "community/family/tribe" concepts which have a basic belief that no one stands alone, but rather functions as part of a group. Therefore people are taught to think in terms of group rather than individually. Responding to a question about "how do you feel" may engender some confusion. The counselor may read this as indecision or inability to express feelings, when in fact the person is trying to decide how the answer would apply to the group. (Sue & Sue, 2003, p. 107).
- A statement in the beginning of the session about the cultural differences might help to allow for correction of cultural misunderstanding by the client. Phrases such as, "I do not understand all about your culture, so please let me know if you feel I am misunderstanding" may be helpful.
- The counselor should try to identify the client's expectation and view of the counseling relationship. This will be a helpful guide to the counselor as to how to direct the session.
- Due to the "group" thinking present in some cultures, the counselor may be more directive at first in the way in which the counseling session goes as this may be the

way that communication is usually done in that culture. However, it should be a goal to involve the client as much as possible in making their own decisions (Sue & Sue, 2003, p. 108).

- Be familiar with cultural forms of greeting and the appropriate way to address the client. Often first names are reserved for very close friends and families. Titles or last names with a salutation may be best. Always ask how you should address the client.
- Find out about normal communication styles and rules. Is eye contact appropriate, what is appropriate distance, what about touch? In “attending” or active listening, leaning toward the client may not be considered appropriate and may be perceived as a sexual gesture.
- A discussion of sexual or other intimate matters, particularly if the client is older than the counselor, may not be culturally appropriate. Try to respect that. Eventually, especially if this is an essential issue, enough trust may be gained to allow for this type of discussion.

## Universals in Counseling

Despite differences that may be present, there are many ways in which those differences are overcome. Being aware that some of the above may be there should not frighten the counselor but simply provide extra tools of awareness. Many human issues are the same regardless of culture and despite the way in which they are expressed. All people experience fear, hurt, loss and grief. The basic communication and counseling skills mentioned earlier are still effective, regardless of cultural differences. Listening, empathy, attending and showing respect often transcend cultural differences. Some studies have shown, in fact, that interaction between those who are culturally different can actually enhance rather than distract due to a sensitivity to the difference and an effort to overcome any barrier that might be present (Butrin, 1992).

Counselors are encouraged to rely on the Holy Spirit and divine guidance to give each person in the session the ability to go beyond the difference and to positively affect the cross—cultural encounter with extraordinary illumination. Depending on the religious convictions of the client, prayer for that very thing to occur at the beginning of the session may help to immediately bring a spiritual bond between the two. If the counselee is not a believer, the counselor can still rely on the Holy Spirit to give guidance, and hopefully at some point of the relationship, offer spiritual help and insight as well, when appropriate.

## Questions for Reflection:

- Is counseling for emotional issues common in your area?
- What type of training do most counselors receive?
- Do you feel that a course in pastoral counseling such as that received in Bible School is sufficient for dealing with issues of HIV/AIDS?
- If you were seeking a counselor, what attributes of that counselor would be most important to you?
- Is there a stigma attached to seeing a counselor in your area?
- What are ways that the stigma attached to counseling might be reduced?
- Is the church involved with counseling? For HIV/AIDS? If not, why not?

# Lesson Ten

## Pre and Post—test Counseling for HIV Testing

### Lesson Objectives

At the completion of the lesson students will be able to:

1. Evaluate the key components to pre—test counseling and analyze the importance of these components in the students own context
2. Construct an appropriate framework for assisting individuals to prepare for the outcome of an HIV test
3. Critically evaluate the dynamics involved in the post—test scenario and assess the most effective means of intervention or assistance
4. Assess the spiritual implications of the HIV pre and post test situations and determine ministry approaches that would be appropriate to the local context of the student

### Scenario for Discussion/Consideration:

**Alicia** — Barbara, I am so upset. My husband has been coming home late. I smell liquor on his breath, but more than that I'm pretty sure he is seeing other women.

**Barbara** — Oh Alicia, what makes you think that?

**Alicia** — I found a women's scarf in his pocket—he acts guilty—he never has good excuses for where he's been and someone told me they saw him all over a woman in a bar. I'm scared to death that he might give me that AIDS disease everyone is talking about.

**Barbara** — Well Alicia, I know just what you're talking about. I went through all of this with my husband before he got sick and died. Sometimes I wonder if he might have had AIDS too. The doctors never said he did, but I heard the nurses whispering and I thought they said he had it. I wish I knew—I wish we both knew.

### Questions for Discussion/Reflection:

- What is happening in the scene above?
- What do these women really fear?
- What may happen if they pursue HIV testing?
- How might this scene play out in your area?

## General Information about HIV/AIDS

When people decide to be tested for HIV, it is a very important opportunity to give information and facts about HIV/AIDS. Many people who come forward to be tested are not really sure what it is, how it is transmitted and what to expect if they are positive.

Since the time to give these facts may be limited, it is important that a short, accurate presentation be made, either to a group or individually and that written material be put in their hands so that the main points can be reinforced and shared with others.

## Effective Teaching Methods for Adults

Since most of the persons who will come for testing will be adults, it is best to use teaching styles which are most effective for adult learners. *Effective teaching methods are usually interactive or participatory.* That means that rather than an instructor getting up and giving facts, the instructor becomes a facilitator who interacts with the persons being taught. This is done by asking questions, using role—plays, finding out what is known and then building the facts into the presentation. Visual aids also help because most persons are visual learners. People retain information best by “seeing” and “doing.”

A flip chart or transparencies are good tools to visually reinforce the information being given.

Training videos may be a helpful reinforcement, but do not meet the need of interaction. People often have many questions and need a well—informed person facilitating the discussion who can answer most questions related to HIV/AIDS.

Ideally, when a person comes to the testing site, and a small group is gathered, the interactive session about the facts of AIDS and what the testing will mean should be the first activity.

## Important Information to Give Pre—Test

The following information should be included in the pre—testing group discussion, with couples, or one—on—one with individuals:

- What is AIDS?
- What happens in the body when infected with HIV?
- How is HIV transmitted?
- How is HIV not transmitted?
- What are some of the common myths about HIV/AIDS?
- What are the signs that someone has AIDS?
- Treatment and cure for AIDS
- How to prevent getting and spreading AIDS
- HIV and pregnancy
- How do you know if you have HIV/AIDS?
- Spiritual help in the time of crisis

The above list seems like a lot of information to give in a short period of time. This is why it is important that it be in a format that gives simple explanations while using the participatory style. *It is best done before the test.* If a positive result is received from the testing, it is not a good time to try to give important information. Persons will often be in shock or in a state of anxiety or panic and not able to comprehend a great deal at that time. They will probably have many questions later when the reality of the situation has settled in. A return time to talk and bring questions is really important.

Begin with the question, “What is AIDS?” This is a good way to assess the level of knowledge of the group or individual. Using a visual aid which can be given to the person such as the teaching booklet, *AIDS, What You Should Know*, will be helpful in retention of information. The material should be transmitted using questions, role—plays if time permits, and discussion.

Once the facts about AIDS have been covered, the facilitator should move into a discussion about the test that will be given. The final part of the teaching on AIDS should end with, “How do you know if you have HIV?”

**Explanation of the Test** — The following are important points that should be covered about the test itself: (Refer to earlier chapters for information on the topics below:)

- How confidentiality will be guarded
- How the test will be done and what the results mean
- If a follow—up test is needed
- When results will be available
- What positive and negative test results mean
- Discussion of how one might feel if the result is positive
- Spiritual counsel regarding God’s faithfulness in times of difficulty

*Note: The first part of the teaching about facts about AIDS can be done by anyone who has been trained in AIDS information and effective teaching styles. However, the explanation of the test, or at least the discussion of how one might feel if getting a positive result, would best be handled one—on—one or with a couple and preferably by someone with some training in counseling or “helping” skills.*

## **Discussion of how one might feel if the results are positive**

It is important that people can begin to think about what they will do and how they will respond to a positive test result. It is also good to bring up the fact that a negative result may not mean that they are HIV free and that retesting may need to be done. Good preparation at this time will help in the response to a positive test outcome.

It is good to help people prepare for the test results by developing a plan of action.

## **Scenario for Discussion/Consideration:** (continued from earlier discussion)

### *Alicia and Barbara at the testing center*

**Alicia** — (wringing hands, acting nervous, getting up and pacing) I'm scared to death. I think this is a mistake. I thought I wanted to know but now I'm not so sure. Once I know then I'll know I'm dying. I don't want to die Barbara.

**Barbara** — I know what you mean. Maybe not knowing is better than knowing. Anyway, what can we do about it? What is, just is. It's really not in our hands. Still though, I'd like to get married again and I don't want to give it to someone else.

**Alicia** — I'm sorry Barbara—I just can't stay here. I can't go through with it. I'm leaving. If I die I die, but I can't do this.

## **Questions for Discussion/Reflection:**

- How common is it for people in your culture to feel “fatalistic” in their thinking—what will be will be?
- What might be said to address that kind of thinking, especially when it comes to testing?

It is helpful to engage people in conversation or dialogue as soon as possible when they enter the testing area. Sitting around with time to think might engender the exact scenario played out in the role—play. Once the teaching is done, the counselor might begin individually or with couples with the following questions:

- How are you feeling about being tested?
- What are your concerns?

## **If you test positive:**

- What will you do?
- Who will you tell?
- How will you tell your sexual partner and encourage him or her to be tested?
- What will this change in your life?
- How do you think others will respond to this news? How will that affect you?
- How will you avoid spreading HIV to others?
- How will your relationship with God factor into this situation?

## **If the test is negative:**

- Do you understand what a negative result means?
- After hearing the teaching, do you have some ideas how you might prevent getting HIV?

## For non—believers:

- How might you receive spiritual help in this situation?
- Who would you turn to provide emotional, spiritual and social support?

## Spiritual Implications

When dealing with persons who have a relationship with God, it is good to talk about the spiritual implications of the test results, whether they are positive or negative. Some of this may have been addressed with the above question about God being in the situation.

For those who have a strong relationship with the Lord, it is helpful to have some scriptures on hand which refer to God's faithfulness in the midst of difficult circumstances. For some, this will be a comfort and give strength before facing potentially horrible news.

Scriptures that may be helpful are:

Psalm 45:1—5, 10—11	A very present help in time of trouble
Psalm 91	My refuge and my fortress, my God in whom I trust
Psalm 130	Out of the depths I cry to you, O Lord
2 Corinthians 1:3—7	Sharing in suffering and in comfort

## Prayer

Regardless of religious persuasion, most people are open to making contact with the supernatural when facing a potential crisis. Speaking with someone about God is, in many cultures acceptable. A simple question by the counselor asking if the client would like prayer before going into the test will often be gratefully received. The counselor will know when or if this is appropriate but should not hesitate to offer as much spiritual help as possible. Referring the person to a church or pastor for additional spiritual help would probably be most appropriately done in the post—counseling session, but might be worthwhile while the client is still able to absorb information.

## Sharing Christ

By this point in the encounter, the counselor will have a sense of whether it would be appropriate to speak further about a relationship with the Lord and/or offer to pray with the client prior to testing.

It is important not to use the counseling encounter in a manipulative sense to “get converts.” On the other hand, with Holy Spirit sensitivity, it may be a wonderful opportunity to help people move toward a relationship with the Lord that will offer comfort, strength and hope in the potentially difficult times ahead.

Christian counselors should bathe each counseling opportunity in prayer. If the counselor is not familiar or comfortable with sharing his or her faith in Christ, a visit with a local pastor may be helpful. A small pamphlet which explains one's spiritual journey may be useful to help guide the conversation.

## Post—test

Ideally, when the pre—test session is over, the counselor will be able to stay with the client while the test is done and during the waiting period should a rapid test be available. When the test results are given to the counselor, he or she will be right there to begin the post—test counseling. Whenever possible, long waiting periods to “get back to the counselor” should be avoided due to the stress of the situation.

### Scenario for Discussion/Consideration:

Barbara and counselor sitting together

**Counselor** — Hi, Barbara. How are you doing? Sorry you had to wait awhile. I have been so busy today with so many clients. It seems the line never ends. So how are you doing? How about a cup of tea? I bet you could really use a cup of tea.

**Barbara** — Tea? Tea! I don't want tea—I just want to know what you found out. Am I going to die? Do I have it?

**Counselor** — (seeming nervous and ill at ease) Yes, well I'm sure you would like to know that information. You know Barbara, life is not always so easy. Things come our way and we just have to be strong and go on. I mean lots of people seem to deal with things and live their lives and....well, yes, the thing is Barbara ah, well...let's see.

**Barbara** — Just tell me, will you?

### Questions for Discussion/Reflection:

- What is happening in the scene above?
- How is Barbara feeling?
- What is right or wrong about the counselor's approach?
- What would you say to Barbara?

## Post HIV Test Counseling

One of the great advantages of the HIV rapid test is that test results can be given within a few minutes. This eliminates the agony of waiting for days to hear potentially bad news. The rapid test provides:

- A means of completing the educational process
- Preparation for the test results by a trained counselor or helper
- Help and support with the results
- The opportunity to arrange a follow—up visit

Although the pre—test counseling is separate from the post—test, ideally they are linked. It is best if the same counselor can be available for both so that the counselor already has a feel for the needs of the client and will have a sense of the best way to deal with the post—test session.

It is important for the counselor to be prepared for sharing bad news. As stated in the previous chapter, bathing the encounters in inward prayer is helpful and allowing room for the Holy Spirit to work in and through the counselor is also essential. Spirit—filled believers will be very dependent on divine guidance during these difficult sessions.

Additionally, the counselor needs to have tried to work through his or her own feelings about a positive result. Some counselors may be HIV positive themselves and having to deliver the same bad news that they had heard may bring up a lot of past emotion. This can actually enhance the time with the client in terms of empathy for their situation, but the counselor also needs to be able to be enough in control to communicate what needs to be said.

## **Counseling for Negative Test Results**

**High risk behaviors and the window period** — Delivering the news of a negative test result is a relief for the counselor and client. However, it is a necessary part of the role of the counselor to determine with the client whether there was high risk behavior that would indicate a “window period” possibility. The counselor should refer to the assessment form that had been filled out in the first session and together with the client determine if there had been any high risk behavior that would indicate that a second test should be done. If there has been risk behavior, it is important to schedule a follow—up visit in three to six months and the client be strongly encouraged to return.

**Avoiding Infection** — A negative result also presents an excellent opportunity to reinforce avoidance of behaviors that could cause HIV infection.

**Spiritual Issues** — It is also an excellent opportunity to speak to the client about spiritual issues. The negative result, if no risk behaviors have been determined, can be a way of speaking about a “gift from God,” a new chance to live life, etc. Asking questions about what the client will do differently may lead into a discussion about spiritual matters.

Having prayer together for a recommitment to a life of purity, helping others, or whatever seems most appropriate for that individual, will be helpful.

## **Counseling for a Positive HIV Test Result**

The way in which the client has been prepared for the test results and the way in which the results are communicated can help to make a difference in the way in which the client responds to a positive report.

Some people will actually be expecting a positive report and will not be as surprised or shocked as one might think (Granich & Mermin, 2003 ). However, regardless of expectation, preparation or a great communication style, there is always going to be a reaction when the confirmation of infection is given.

The news should be given in a quiet, private place where the client can react in any way that they wish. The counselor, who may be very uncomfortable with delivering this news, should not avoid the subject by making small talk or making nervous gestures. The news of a positive result

should be communicated openly, honestly and without fluffy language. The use of neutral words is helpful rather than saying “I’m *afraid* I have *bad* news,” which attaches value to the message, simply say, “Your HIV test has shown that you are HIV positive.” One could say, “Your HIV test is positive,” but that may allow for clients to “depersonalize the result” as the test is positive rather than that they themselves have HIV (Granich & Mermin, 2003).

After giving the news, it is good to wait for the client to respond. Though it is not always possible to predict how someone will react to this news, the counselor may have some idea from their first encounter and the previous discussion about how the client would feel if the result was positive. It is hoped that the pre—test discussion would have already begun to surface some of the feelings.

The following are some things that the counselor should avoid when giving an HIV positive report: (van Dyk, 2002)

- Don’t hedge or try to dodge the issue.
- Don’t beat around the bush.
- Don’t break the news in a public place.
- Don’t give the impression of being rushed or distracted.
- Don’t argue or interrupt.
- Don’t say “Nothing can be done.”
- Don’t react to anger with anger.
- Don’t say “I know how you feel.”
- Don’t be afraid to say “I don’t know.”

**Culturally—defined expression** — The way in which feelings are expressed may be somewhat culturally defined. What a person has been taught or seen as appropriate ways of expressing feelings will differ from culture to culture. However the expression, there are common feelings that people have after finding out they are HIV positive (van Dyke, 2002; Granich & Mermin, 2003)

**Denial** — The feeling that the test is wrong; it can’t be true. Some will strongly insist that the test must be wrong. The counselor might calmly mention that the test is rarely wrong, but that the two of them could discuss the possibility of a second test at a later time. Many will say, “This just can’t be happening to me.” A follow—up statement by the counselor might be, “I know it’s hard to believe or comprehend right now. It’s a very scary thing to think about.”

**Shock/disbelief** — Despite preparation and the pre—test counseling, the reality of the news is so enormous that the client may not fully take it in and may respond with shock and disbelief. Statements, like — “No it can’t be true,” “I can’t believe it,” “Why me?” are common statements of shock and disbelief. Some persons will leave the counseling session in this state—confused, not focusing mentally and responding as though a physical blow had been delivered to them. In fact, the emotional blow has overwhelmed their ability to cope and there is some emotional shutdown occurring until the mind has time to absorb the truth. Counselors might say, “I know this seems overwhelming right now, but I would like to talk with you either now or later about some things you can do to help yourself.”

**Anger** — Often a response of anger is the first response people have when hearing they are HIV positive. The anger may be directed at the one who may have given them HIV, at God, at the counselor or at themselves. It may be expressed by an angry outburst at one of the above, by clenched fist, by jumping up and pounding something, by bursting into a verbal tirade, by swearing or even screaming. An angry response is no doubt one of the more challenging for the counselor. It is important to allow the person to express their anger as long as they are not putting the counselor or themselves in danger. Sitting calmly and allowing the venting is best. Once the person has calmed down, the counselor might say, “It is pretty normal to feel angry right now. Tell me more about what you are feeling.”

**Fear** — Fear may be the most basic of all the feelings a person has, particularly once the reality of the diagnosis has sunk in. Fear and hurt are often the real source of anger which may just be a symptom of these deeper issues:

- Fear of death is probably the single most common element in the HIV diagnosis. Many who receive this news will already know someone who has died from AIDS and all that that implies.
- Fear of the unknown may be there for those who have had no exposure to someone with AIDS.
- Fear of rejection is very real, especially for women who fear that their husbands and/or their families may reject them.
- Fear of stigmatization and discrimination is also very real.
- Fear for the welfare of their families and children is another factor.

Though the shock and anger or denial may supercede the expression of fear in the immediate time after the news has been given, ***fear is probably the most pervasive of emotions with which the person with HIV will cope.***

**Sadness/hopelessness** — Whether these feelings are seen in the post—test session will depend on how much the client thought that he or she would be positive and how prepared he or she was for this result. The confirmation of his or her suspicion may bring an overwhelming sadness which may be expressed by quiet crying, sobbing, or simply a heavy sigh of hopelessness. When asked by the counselor, what is being felt, a response may simply be the word, “heavy” or “sad.”

**Depression** is common in any person who has received word that he or she is dying and the person who is expressing extreme sadness may already be depressed or may slip into that state. The counselor may try to elicit more information about what the person is feeling and try to connect him or her with a counselor for ongoing care or try to get the person to come back for follow—up visits, depending on the resources available.

**Suicidal thoughts** — In both pre— and post—test counseling, the counselor should be listening for any reference to potential suicidal tendencies. If a client says, “If I have HIV I just wouldn’t want to live,” or “Any kind of death would be better than dying like Uncle John died,” or “I’d rather die than tell my family I have AIDS,” the counselor should pursue the subject of suicide and try to determine if this is a real possibility or if the person is just using a manner of expression.

If in the post—test session, the counselor feels that suicide is something the person is thinking of, it should again be addressed. If a friend or family member has accompanied the client, that person may need to be instructed to stay with the client for a few days. Depending on the resources of the testing area, a staff member or church member may be able to make a home visit within hours of the test results to be sure that the person is not alone. The testing site should develop a set of guidelines as to what will be done if a suicidal tendency is present.

**Instilling hope** — An important role of the counselor in the post—test session is to try to offer realistic hope. It may be helpful to say that people who take care of themselves are living longer, that they are not going to die immediately, that there are drugs being developed that will help them, etc. Though one does not want to give false hope, there are positive things that can be said to help counteract the hopelessness.

It is important to talk about getting rest and trying to eat properly. Stories of people who have taken care of themselves and lived for years may be helpful to instill hope.

It is important for the counselor to remember that very little of what is said during the post—test phase may be heard or absorbed by the client. Usually the shock of the news is so numbing that the ability to take in information is minimal. Just being supportive and listening may be the main role in the post—test time. This underscores why the pre—test counseling session and the planning of what to do at this phase is so important.

**Spiritual help** — Depending on the religious persuasion of the client, the counselor may find it appropriate, after the client has expressed whatever they are feeling, to ask if he or she would like to pray together. Some persons will be too distraught or too angry with God to receive or wish for prayer at that time. Others will find it comforting to make that spiritual connection. Depending on the emotional state of the client, the counselor may wish to speak of hope in a relationship with Jesus and what that means for eternity. Once again the counselor will want to be reliant on the Holy Spirit to try to determine what the needs, and particularly the spiritual needs of the client are, and what would bring most comfort and help at this time.

## **Follow—up Counseling**

Most ideally, counseling for persons with a new diagnosis of HIV should continue for several months until they have worked through the stages of grief and have sorted out a plan for their lives. For some who have a strong support system of family and friends, this may be less necessary. But for those who have not shared their status or who are having difficulty adjusting to their status, more emotional support from a counselor may be very helpful.

If the HIV testing center is church—based, as will be discussed in Chapter Eight, the pastoral staff, who should also receive basic training in counseling, may be able to provide the support that is needed. Support groups may be organized by the church, the community, or the testing facility. Though these may not always be as effective as one—on—one counseling, the advantage is that more people can be served with limited resources. It is also often helpful for people with similar experiences to share their stories.

## **Counseling for HIV Positive Pregnant Women and for Children**

Women who are pregnant who are coming for testing should be given some specific information regarding the possibilities of transmission of the HIV to their unborn child. They also need specific information concerning ART's that may be available to help reduce the risk of transmission to the baby.

Pre—test counseling for pregnant women is often done in prenatal settings where a number of expectant mothers can be talked to and encouraged to be tested. The information that needs to be transmitted is too lengthy to be included in this course. However, a section is given to this topic in the HealthCare Ministries Training Manual, HIV Testing and Counseling (Butrin, 2004).

Children who will be tested also represent a special population that requires specialized care and counseling before being tested. Some will not really understand what is going to happen or what the test means. However, some explanation of what the test will entail should be given. The child should be questioned about what they do know and what they are fearing about the test.

A section in the HealthCare Ministries Training Manual, HIV Testing and Counseling deals with the special needs of children (Butrin, 2004).

## **Care for the Counselor**

Counselors spend most of their time listening to and dealing with people's problems. Even when not dealing with a life—threatening issue such as HIV/AIDS, counseling can be very draining for counselors. When having to give people a test result that ultimately means that their life will end, the counselor can become very depleted emotionally.

A condition termed, "compassion fatigue," can develop. This is when the caregiver or counselor becomes emotionally fatigued from the drain of "bad news" and the suffering and trauma of the people they serve. It has also been termed, "burnout" and "secondary post—traumatic stress disorder."

**Symptoms of compassion fatigue are:** (Figley, 2002).

- Extreme fatigue
- Depression
- Inability to eat or sleep
- Inability to stop thinking about clients and their problems
- Dread of going to work and many similar symptoms

**Prevention of compassion fatigue:**

- The best way to avoid becoming emotionally fatigued is first of all to be aware that it can occur and be monitoring oneself for the symptoms mentioned above.
- Secondly, it is good to form a support group with other counselors who understand the types of things being dealt with each day.

- Allow get—away times which may need to be more frequent than the usual vacation times.
- Be sure that time with the Lord is appropriated for each day and ask the Lord for protection against emotional fatigue.

Bathe the counseling process in prayer each day and give the burdens of those served, back to the Lord each evening. Only the Lord can really bear the heaviness of the burdens experienced by the clients of the counselor. One can almost symbolically place these at the Savior's feet each evening. "Casting all your care upon him, for he cares for you." (Psalm 55:22)

## **Questions for Reflection:**

- Have you ever considered being tested for HIV? Why or why not?
- What types of emotions do you think you might have if you thought there was any risk that you would test positive? Why?
- What would you want to know before you are tested? Why?
- How important would confidentiality be to you? Why?
- Would you feel comfortable going to a testing program connected with your church? Why or why not?
- Would you want your pastor to know the results of your test if it were positive? Why or why not?
- How do you think you would feel if your tests results were positive?
- How do you think you would feel if your test results were negative?

## References Cited

- A Survey of truck drivers demographics and media habits in four border towns of Uganda. (2004). Retrieved on January 22, 2004 from, <http://www.ugandadish.org/TruckDriversSurveyReport.doc>.
- Africa's Children. (1994). *Edward the Elephant*. Missouri: Assemblies of God
- Barnett, T. (2003). HIV has changed the world: Food security and disease what we need to know. *The Courier ACP—EU*, no. 197. Retrieved on January 23, 2004, from <http://www.uea.ac.uk/dev/publink/barnett/courier197.pd>
- Butrin, J. (1992) Cultural diversity in the nurse—client encounter. *Clinical nursing research*, 1(5).
- Butrin, J. (1997). *Who will cry for me?* Florida: Poor Richards.
- Butrin, J. (2003). *HIV testing and counseling: A guide to train workers in voluntary testing and counseling skills for HIV/AIDS*. Missouri: HealthCare Ministries Publications.
- Butrin, J. (2003). *HIV/AIDS, What you need to know*. Missouri: A HealthCare Ministries Publication.
- Butrin, J., Morgan, C., Davis, B., & Pandolfo, J. (2002). *A Manual for Hospice Care*. Missouri: A HealthCare Ministries Publication.
- Du Toit, A., Grobler, H., & Schenck, C. (1998) *Person—centered communication: The theory and practice for the helping professions*. Halfway House: Thomson
- Egan, G. (1998). *The skilled helper; A problem management opportunity—development approach to helping*. Pacific Grove: Brooks & Cole.
- Faith Based Organizations—UNGASS Consultation Meeting (February, 2001). *Statement of faith*. Retrieved June 21, 2003, from <http://www.hdnet.org/UNGASS%20docs/UNGASS%20infl/Faith%20Based%20Organization>.
- Figley, C. (2002). *Compassion Fatigue*. New York: Wiley and Sons.
- Gladding, S. (1996). *Counseling: A comprehensive profession*. London: Merrill Prentice Hall Publisher
- Granich, R. & Mermin, J. (2003). *HIV health & your community: A guide for action*. Berkeley, CA: The Hesperian Foundation.
- Harris, M. (n.d.). *The truck drivers' chapel ministry manual*. Retrieved January 21, 2004, from <http://www.b2thumpr.com/Heaven/truck1.html>
- HIV and the Americas: An epidemic with many faces, PAHO/WHO/UNAIDS (2001) [http://www.paho.org/English/HCP/HCA/faces\\_final.pdf](http://www.paho.org/English/HCP/HCA/faces_final.pdf)
- International Vitamin A Consultative Group. (2001). IVACG statement: Safe doses of vitamin A during pregnancy and lactation. Retrieved June 5, 2003 from <http://www.ivacg.ivacg.ilsa.org>

- Kilbourn, P. (1997). *Street children: A guide to effective ministry*. Monrovia, CA: MARC Publications.
- Kilbourn, P. (2002). *Children affected by HIV/AIDS*. Monrovia, CA: MARC Publications.
- Maternal and Neonatal Health (2002) *Mother—to—Child Transmission of HIV/AIDS: Reducing the Risk*. Retrieved on June 25, 2003, from <http://www.mnh.jhpiego.org/best/mtchiv.pdf>.
- Myers, B ( 1998 ). *Walking with the poor*. Maryknoll, NY: Orbis Books.
- Long, V.O. (1996). *Facilitating personal growth in self and others*. Pacific Grove: Brooks & Cole.
- Richer, L., & Swart—Kruger, J. (1995). AIDS—risk among street children and youth: Implications for intervention. *South African Journal of Psychology*, March 25(1). 31—38.
- Richter, L. (1997). Street Children and HIV/AIDS. *AIDS Bulletin*, Dec 6(4). 4—6.
- Robinson, J. (2001) Secular development. In S. Rowland (Ed.), *Multiplying light and truth* (pp. 55—70). Mumbai, India: GLS Press.
- South Africa Training Programme (SAT). (2003). *Guidelines for counselling children who are infected with HIV or affected by HIV and AIDS*. Retrieved on May 22, 2003, from [http://www.satregional.org/pubs/Counselling\\_Children.pdf](http://www.satregional.org/pubs/Counselling_Children.pdf)
- SPCM 301: Communication across cultures lecture handouts. Retrieved on January 23, 2004, from <http://www.siu.edu/~ekachai/culture.html>
- Sue, W. D, Sue, D., & Sue, D.W. (2003). *Counseling the Culturally Diverse: Theory and Practice*. New York: John Wiley and Sons.
- United Nations Development Program (UNDP). (n.d.). Social Economic and Governance Dimensions of the HIV/AIDS Epidemic in Eastern Europe, CIS and Baltic States. Retrieved on January 23, 2004, from <http://www.undp.org/hiv/activities/rbec.htm>
- UNAIDS (2003). AIDS epidemic update. Retrieved on January 19, 2004, from [http://www.usaid.gov/pop\\_health/aids/countries/lac/Guyana.html](http://www.usaid.gov/pop_health/aids/countries/lac/Guyana.html).
- van Dyk, A. (2002). *HIV/AIDS care and counseling: A multidisciplinary approach*. South Africa: Pearson Educators
- World Health Organization/UNAIDS (1999). HIV in pregnancy: A review. Geneva. Retrieved on May 25, 2003, from <http://www.who.int/health—topics/hiv.htm>.
- Youth and HIV/AIDS: Can we avoid catastrophe? (n.d.). *Population Reports, Series L*, No 112. <http://www.infoforhealth.org/pr/112/112print.shtml>. Retrieved on January 22, 2004.